Paramedics and the Chance of a Better Outcome:

Psychological Health and Safety and Employer Liability

A Thesis Submitted to the
College of Graduate and Postdoctoral Studies
In Partial Fulfillment of the Requirements
For the Degree of Master in Public Policy
In the Johnson Shoyama Graduate School of Public Policy
University of Saskatchewan
Saskatoon

By

Jennifer Chouinard

Permission to Use

In presenting this thesis/dissertation in partial fulfillment of the requirements for a Postgraduate degree from the University of Saskatchewan, I agree that the Libraries of this University may make it freely available for inspection. I further agree that permission for copying of this thesis/dissertation in any manner, in whole or in part, for scholarly purposes may be granted by the professor or professors who supervised my thesis/dissertation work or, in their absence, by the Head of the Department or the Dean of the College in which my thesis work was done. It is understood that any copying or publication or use of this thesis/dissertation or parts thereof for financial gain shall not be allowed without my written permission. It is also understood that due recognition shall be given to me and to the University of Saskatchewan in any scholarly use which may be made of any material in my thesis/dissertation.

Disclaimer

Reference in this thesis/dissertation to any specific commercial products, process, or service by trade name, trademark, manufacturer, or otherwise, does not constitute or imply its endorsement, recommendation, or favoring by the University of Saskatchewan. The views and opinions of the author expressed herein do not state or reflect those of the University of Saskatchewan, and shall not be used for advertising or product endorsement purposes.

Requests for permission to copy or to make other uses of materials in this thesis/dissertation in whole or part should be addressed to:

Head of the Johnson Shoyma Graduate School of Public Policy
141 – 101 Diefenbaker Place
University of Saskatchewan
Saskatoon, Saskatchewan S7N 5B8 Canada

OR

Dean
College of Graduate and Postdoctoral Studies
University of Saskatchewan
116 Thorvaldson Building, 110 Science Place
Saskatoon, Saskatchewan S7N 5C9 Canada

Abstract

Canadian paramedics experience high rates of work-related PTSD and suicide. Relevant scholarship has claimed that paramedics often experience more stress from a lack of support within the workplace than from the traumatic nature of their work. The purpose of this study was to determine what underlying legislation might support the implementation of comprehensive support programs for Canadian paramedics. In-depth interviews were conducted with paramedics and key actors from paramedic services in Saskatoon, Canada and Queensland, Australia; a workplace with an emerging response to paramedic mental health and one with an established, multi-modal, comprehensive health promotion program, respectively. The Saskatoon sample provided narratives demonstrating a lack of support in the workplace as the primary cause of stress while the Brisbane sample presented as satisfied with their support services and unconcerned with PTSD and suicide. The major difference between the two cases was the employers' level of assertiveness in promoting social support within the workplace, owing to underlying occupational health and safety law. Australia's primary duty of care model supports a culture where the employer is primarily responsible for the prevention of work-related injuries. In Canada, occupational health and safety law does not hold any actor primarily responsible for injury prevention, yet psychological health and safety in the workplace is an emerging liability issue for employers. This thesis explains Canada's first responders' mental health crisis as a sociopolitical problem rather than a collection of individual tragedies. Much can be learned from Queensland case study where the employer was mandated to actively promote psychological health and safety within the workplace rather than ad hoc PTSD and suicide intervention programs. Finally, the struggle to respond to high call volumes was among the top psychological health concerns for all participants, demonstrating that resourcing levels need to be addressed in order to fully promote better health outcomes.

Acknowledgements

I would like to thank the Johnson Shoyama Graduate School of Public Policy for supporting this study that included both Canadian and Australian case studies. More specifically, I would like to thank Dr. Brett Fairbairn and Dr. Alana Cattapan for their patient and attentive supervision. Thank-you to my committee members, Dr. Keith Walker and Dr. Phil Woods, and to my examiner Dr. Erica Carleton. A special thanks to Amy Hassett, Amanda White, Erica Schindel, and Dr. Murray Fulton for their additional time and attention.

I would like to thank Medavie Health Services West and the Queensland Ambulance Service, especially the Priority One team, for recognizing the value of these tough conversations. A sincere thank-you to the paramedics and decision-makers who participated. It was a privilege to hear your stories, shared with such candour and authenticity.

To my friends and family who cared for me in complicated and painful situations over the past five years—you are where I found safety. Thank-you to the paramedics who responded to the medical needs of my loved ones as well as my own, throughout this project. For the lives you saved and final hours you attended, I am humbled and forever grateful.

To the many families and friends
who continue to grieve the first responders we have lost to suicide.

To my former coworkers,
for all the smiles, laughter, and connection.

Table of Contents

Acronyms

PTSD: Posttraumatic stress disorder

PTS: Posttraumatic stress

CISD: Critical Incident Stress Debriefing

R2MR: Road to Mental Readiness

MHCC: Mental Health Commission of Canada

QAS: Queensland Ambulance Service

EAP: Employee Assistance Program

OH and S: Occupational Health & Safety

PSO: Peer Support Officer

PPC: Professional Psychologists Counsellors

WCB: Workers' Compensation Board

Chapter 1: Introduction

On March 17, 2015, 27-year-old paramedic Jack Spyker was declared dead by his colleagues. He died by suicide in North Battleford, Saskatchewan. At his funeral, Spyker's close friend and fellow paramedic described Jack's character and some of the causes he attributed to Jack's suicide. The following excerpts are from his eulogy.

Jack was described as someone enjoyable to work with; someone who was "truly meant for EMS" and who showed "obvious intelligence and dedication." Jack's eulogist described the strong bond they shared throughout the diverse calls of paramedic work. He also described the distressing change he witnessed in his friend who had begun to suffer "a lack of self-confidence and never thought he did well enough, and would be overly critical of himself for minor mistakes… [Jack] was being pervasively negative and unusually critical—everything sucked." In spite of this struggle, "Jack had indeed tried to reach out and seek help for his depression on at least two occasions, even going as far as speaking to specialists in the mental health […]; he just happened to be one of the people who the mental health system failed…" The final words of the eulogy given at Jack Spyker's funeral were these: "Mental health needs to stop being a stigma; our inability to deal with it as a society hurts and kills people every day. If Jack hadn't been worried about losing his job and his calling due to mental sickness, he might still be with us today."

Canada has a big problem when it comes to first responders' mental health. Many are developing posttraumatic stress disorder (PTSD), and too many are committing suicide, as evidenced by media reports that pay tribute and call attention to the issue (Armstrong, 2014; Bergen, 2015; Quenneville, 2018; Roth, 2017; Smith, 2019). At the micro level, a person's traumatic experience and suicide can be next to impossible to fully understand but at the macro level, it has become an established trend—one that emergency services industries are hurrying to address. Typically, employers offer personal counselling services through Employee Assistance Programs (EAPs) but more is needed to create a supportive connection within the workplace itself. Often, we think psychologically injured first responders struggle to cope with the traumatic nature of their work but when we hear from frontline workers, many report that the bigger issue is not feeling supported or valued in their workplaces.

At the forefront of supporting emergency service staff members is the Queensland Ambulance Service; a major contributor to the field of mental health in the emergency service workplace (Shakespeare-Finch et al., 2014). In this service, PTSD and suicide are not the norm but are quite rare, owing to a comprehensive Employee Assistance Program (EAP) that centres around a robust peer support model (Scully, 2011). Conversely in Saskatchewan, work-related psychological injuries are increasing rapidly; 213% since 2015 (Lozinsky, 2020), despite the recent changes to workers' compensation legislation intended to curb injury rates by better recognizing psychological injury (Baynton & Fournier, 2017).

The similarities and differences between the two models of support in Queensland and Saskatchewan have profound implications for how paramedics experience their work life and consequently, their mental health. In this thesis, I interrogate these two models, asking: if robust peer support models are an effective means of responding to traumatized first responders, as seen in Queensland, why are they not more commonly used in Saskatchewan? Further, why would the

Queensland Ambulance Service invest in such a robust peer support model? What policy environments allowed for such different models of care? Improving first responders' mental health outcomes involves even broader questions about how psychologically injuries manifest in the workplace. What are the differences in how workers and employers understand experiences of stress, injury, and support? What does this say about how paramedics are valued?

In this thesis, I argue that underlying the overall increase in work-related mental health injuries in Canada is an inequitable distribution of responsibility for workplace health, safety, and injury. For over a century, workers' compensation law and occupational health and safety law have outlined how employers and workers ought to navigate physical safety and physical injuries. However, when it comes to the prevention of psychological injuries, a lot has yet to be written. I contend that Saskatchewan's current approach to paramedics' mental health does not do enough to prevent adverse outcomes because it fails to require employers to address organizational factors that contribute to ill health. There are lessons to be learned from a different model of care, the one developed by the Queensland Ambulance Service, which has achieved substantially better outcomes by targeting both individual and organizational factors. That is, a model in which the employer takes an assertive role in *normalizing* posttraumatic stress by offering a comprehensive, multi-modal support program that seeks to promote supportive connections within the workplace.

This introduction lays the groundwork for this argument by reviewing how relevant scholarship has described paramedics' experience of psychological distress as well as the traditional EAP approach to caring for employees. I explain the contemporary employment relationship as it evolves to capture psychological health and safety in the workplace. I offer a dynamic view of paramedic stress by discussing the impact of organizational factors and the underlying employment relationship. I include discussion of an alternative paradigm; posttraumatic stress as part of a broad posttraumatic growth process. I also discuss the challenges presented by a neoliberal view of mental health as mainly the employee's responsibility. This introduction closes with a clarification of the scope of the thesis and an outline of the chapters to come.

1.1 Mental Health Crisis Among First Responders: Paramedics

The vast majority of emergency service personnel —professions including police officers, fire fighters, paramedics, and many others — report experiencing a great deal of personal growth, kinship, and resilience as a result of their work (Murray, 2016; Shakespeare-Finch et al. 2007). Still, they are at a higher risk of work-related psychological injuries, such as PTSD, depression, anxiety, substance abuse and suicide (Carleton et al., 2018a; 2018b; Drewitz-Chesney, 2012; Murray, 2016; Scully, 2011). Of the emergency service groups, paramedics engage in the highest number of the most extreme, uncontrolled, and emotionally intense interactions with the public (Drewitz-Chesney, 2012; Murray, 2016; Regehr & Millar, 2007). In Canada, they also suffer the highest rates of psychological injury (Carleton et al., 2018a). In a 2018 Canadian study on first responders' mental health, 49% of paramedics screened positive for at least one mental health disorder and 9.3% of paramedics reported a suicide attempt, as compared to an estimated 3 – 4% of the general population (Carleton et al., 2018a; 2018b). The most common psychological injury among emergency service personnel is PTSD (Carleton et al., 2018a; Drewitz-Chesney, 2012), a serious health condition characterized by a collection of intense anxiety-related symptoms

including hypervigilance, social isolation, guilt, anger, numbness, depression, substance abuse, and impaired decision-making (Drewitz-Chesney, 2012; Murray, 2016; Rose et al., 2003).

Traditionally in mental health practice, most attention is paid to the individual factors that contribute to ill health, such as individual coping mechanisms, personality, psychological history, and sociodemographic characteristics (Cadieux & Marchand, 2014; Teghtsoonian, 2009). The same has been true for emergency service workers (Carleton et al., 2018a; Drewitz-Chesney, 2012; Shakespeare-Finch, 2007) where the traumatic nature of paramedics' work is an obvious risk factor to their psychological well-being (Drewitz-Chesney, 2012; Murray, 2016; Regehr & Millar, 2007; Scully, 2011; Shakespeare-Finch et al. 2003). The job requires the paramedic to work through complex medical problems without succumbing to the emotional reality of these interactions while on scene (Murray, 2016). This is not without consequence. The cumulative effect of unresolved emotional suppression can manifest as mental injury (Murray, 2016; Wastell, 2002). The job requires at least some level of emotional suppression that simultaneously supports the well-documented stigma surrounding emotional expression in this field.

Beginning in the 1980s, a debriefing model known as Critical Incident Stress Debriefing (CISD) became a popular means to support first responders in working through their thoughts and feelings in a group setting, following a critical incident (Csiernik, 2005; Mitchell, 1983). Critical incidents were defined as "any situation faced by emergency service personnel that causes them to experience unusually strong emotional reactions and has the potential to interfere with their ability to function either at the scene or later" (Mitchell, 1983, p. 36). The benefits to this model were that it could be employed immediately after a call, which is a particularly important time to offer support to first responders (Drewitz-Chesney, 2012). The structured debriefing model could be offered by a trained peer and includes psycho-education, peer support, emotional release, and stress management techniques (Hurley, Ferriera, & Pain, 2005; Mitchell & Bray, 1990). It was thought to reduce the risk that a paramedic would become psychologically ill and quickly became the most popular and longest standing psychological intervention for first responders worldwide (Hurley, Ferriera, & Pain, 2005). This movement signaled a growing awareness of a duty of care owed to emergency service staff (Murray, 2016).

By the early 2000s, the CISD model's effectiveness was challenged. Not all studies found it effective and many felt that informal debriefings or peer support connections immediately following a critical incident could achieve the same effect (Drewitz-Chesney, 2012; Hurley, Ferriera, & Pain, 2005; Rose, Brisson, & Wessely, 2002; Scully, 2011). Rose et al. (2003) claimed that single-session CISD showed no benefit in reducing the risk of PTSD and warned against its use. Many unintended consequences of this model also came to light. First, many first responders prefer to debrief with family and personal friends and the time spent debriefing at work took them away from their natural support network (Emmerik et al., 2002). Second, debriefings caused some individuals to unnecessarily develop a pathological perception of their posttraumatic thoughts and emotions (Emmerik et al., 2002; Rose et al., 2003). Lastly, if the team coordinating the debriefing accidentally leaves someone out or in the event a first responder cannot attend, their absence can cause additional distress. This field has since developed further understanding that critical incidents are not universal but defined by the personal meaning they carry for each first responder. Events that cause extreme emotional reaction in one individual may not have the same effect on another (Murray, 2016). Today, many emergency service employers continue to offer the CISD model as an option but only as they search for more effective support models.

The next wave of intervention for Canadian first responders focused on reducing stigma, increasing mental health literacy, and strengthening resilience through psychoeducational courses offered in-house, direct to employees. An example of such an intervention is the "Road to Mental Readiness" (R2MR) (since renamed the "Working Mind First Responders") developed by the Department of National Defense and later adapted for Canadian first responders by the Mental Health Commission of Canada (MHCC) (Carleton et al., 2018c). At present, R2MR is the next most popular intervention for first responders in Canada. Carleton et al. described the program as follows:

> The R2MR program provides evidence-based psychoeducation on mental health and stress (i.e. the contemporary Mental Health Continuum Model where mental health spans Healthy, Reacting, Injured, Ill), as well as providing a series of evidence-based cognitive behavioural therapy style skills designed to help participants to manage stress; for example, goal setting, mental rehearsal/visualization, adapted cognitive monitoring (i.e. awareness of self-talk), and arousal management through adapted breathing (i.e. tactical breathing) (2018c, p. 510).

Under R2MR, workers are encouraged to understand their mental health as it occurs along a continuum and to express themselves when in distress so as not to move into unhealthy zones. The goals of the two-day course are: "To improve short-term performance and long-term mental health outcomes" and, "[t]o reduce barriers to care and encourage early access to care" (Mental Health Commission of Canada, 2018). For many industry leaders it has been an important next step for first responders' mental health, but like the CISD model, reviews are mixed (Carleton et al., 2018c).

1.2 Posttraumatic Stress and Posttraumatic Growth

An alternative view suggests posttraumatic stress not so much as a problem but is part of a natural human process known as posttraumatic growth. In 1996, Calhoun and Tedeschi introduced this concept to describe the positive changes that result from crisis and trauma, writing that:

> The experience of a traumatic set of circumstances usually produces distress, disrupts one's understanding of the world, makes salient one's vulnerabilities and lack of power and control, and may make salient one's mortality. These disruptions and reminders tend to not be pleasant, but they may lead to richer, more purpose-filled lives (pp. 7-8).

Following posttraumatic stress, positive changes can happen in perceptions of the self, relationships with others, and general life philosophy. Grounded in this theory, Shakespeare et al. (2003) found that 98.6% of paramedics in the Queensland Ambulance Service (Australia) reported some degree of positive post-trauma change as the result of their work, demonstrating growth and resilience following trauma. In accepting psychological distress as part of posttraumatic growth, Shakespeare-Finch (2007) stressed the importance of normalizing posttraumatic stress reactions rather than pathologizing them. For Shakespeare-Finch (2007) normalizing posttraumatic stress means adopting a salutogenic approach, in which distress is not

denounced but rather, where the factors supporting resilience and health are promoted. By adopting and operationalizing these views, the Queensland Ambulance Service experienced a drastic reduction in PTSD rates (41% between 2005 and 2010) to subclinical ranges, lower than the general Australian population (0.0016%) (Scully, 2011).

Given the extreme differences in Queensland and Saskatchewan paramedics' psychological injury rates, one might consider the possibility that Canadian paramedics' posttraumatic growth processes are being interrupted and pathologized rather than normalized, supported, and protected. Interventions such as personal counselling, CISD, and R2MR may inadvertently be altering the course of posttraumatic growth processes by failing to normalize natural stress reactions and failing to address the organizational factors that help support posttraumatic growth. In order to support posttraumatic growth among paramedics, adequate social support and resource management are crucial (Murray, 2016).

1.3 Organizational Factors: Social Support and Resourcing

In general, paramedics do not actually report that the traumatic nature of their work with the public is the most stressful part of their job nor do individual variables alone explain the high rates of PTSD and suicide in Canada (Carleton et al., 2018a). Instead, paramedics frequently report that the primary source of stress comes from organizational stressors—feeling under-resourced, undervalued, and unsupported by their peers, supervisors, and employers while they respond to the public (Drewitz-Chesney, 2012; Murray, 2016; Regehr & Millar, 2007; Shakespeare-Finch, 2007; Shakespeare-Finch & Scully, 2004).

In terms of troublesome organizational variables, scholars agree that social support and adequate resourcing are critical. Canadian researchers Regehr and Millar (2007) define social support as "…the degree of social and emotional integration and trust between coworkers, supervisors, and others…" as well as any additional resources needed for work tasks that is provided by coworkers, supervisors, and management (pp. 50-51). They point to a lack of social support within emergency service organizations as the most significant variable in paramedics' psychological well-being. Unfortunately, paramedics frequently report a lack of emotional support, formal support services, and adequate resourcing (i.e., equipment and staffing), leaving them feeling undervalued and overwhelmed (Drewitz-Chesney, 2012; Murray, 2016; Regehr & Millar, 2007; Shakespeare-Finch & Scully, 2008). To this end, a 2015 audit of the Toronto Paramedic Service found that paramedics identified a lack of support following a difficult call to be more troublesome than the call itself (Crean, 2015). Such conditions do not support, but rather hinder, posttraumatic growth.

Given that social support and appropriate resourcing are the most important variables in first responders' mental health outcomes, the suffering and loss of life experienced by Canadian paramedics may be more appropriately attributed to problematic, unsupportive working conditions rather than a collection of individual tragedies. For these reasons, experts in workplace health and safety have called for further investigation into how the work environment might be better regulated to reduce risk to workers (Cadieux & Marchand, 2014; Drewitz-Chesney, 2012; Lippel, 2011; Regehr & Millar, 2007; Shain 2010).

1.4 The Workplace Mental Health Movement in Canada

The relationship between mental health and the workplace environment is exceedingly complex, involving interrelated psychological, social, and political factors. It has long been accepted that the workplace is where many people experience a significant amount of positive social integration, however the opposite is also true. Psychological distress from the workplace can manifest as psychological or mental injuries insofar as "mental injury" refers to "any significant impact on mental health that leads to a chronic inability to function as usual at work or at home" (Shain, 2009, p. 43). The long-standing status quo has been to attribute these negative mental health reactions to problematic employees and ignore concerns until they become obvious and disabling work-related psychological injuries (Baynton & Fournier, 2017). This approach is founded in widespread belief that the employers' provision of a standard EAP is sufficient in meeting their obligation to employee wellness (Baynton & Fournier, 2017; Csiernik, 2005).

1.4.1 Employee and Family Assistance Programs (EAPs)

Providing an EAP is the standard approach to mental health support in industrialized nations but these programs vary greatly from one employer to the next (Arthur; 2000; Csiernik, 2005; Shakespeare-Finch, 2007). EAPs are a collection of support services that employers offer employees to assist them in managing personal or professional, social or emotional problems that affect workplace productivity (Arthur, 2000; Csiernik, 2005). In practice, an EAP commonly refers to employer sponsored third party counsellor services, although the term more broadly includes all mental health support services the employer offers the employee (i.e. other benefits, training programs, and debriefing sessions) (Csiernik, 2005). EAPs largely consist of "behavioural interventions" in that they target individual stress reactions and behaviours. These strategies are often superficial and place onus on the individual to identify need and ask for help (Arthur, 2000; Csiernik, 2005; Drewitz-Chesney, 2012; Shakespeare-Finch, 2007). In exchange for these support services, individuals are expected to self-regulate in the workplace. That is, they are expected to be productive without needing time for emotional processing. This arrangement is sold to employers as a mutually beneficial (Arthur, 2000; Csiernik, 2005). EAP services help workers adapt to their environments and manage distress in a way that keeps the work running smoothly (Csiernik, 2005).

In light of dramatic rates of PTSD and suicide, many Canadian emergency service employers have expanded their traditional EAPs from simply including personal counselling and CISD, adding in-house psychoeducation programs such as the R2MR course. These interventions may be effective in their own right, but targeting individual behaviour alone frames mental distress as a pathological manifestation of individual concern, and fails to consider the challenges of a work environment that lacks supportive interpersonal connection (Shakespeare-Finch et al. 2014; Drewitz-Chesney, 2012; Regehr & Millar, 2007). In a 2005 review of Canadian EAPs, Csiernik described this problematic approach:

> [EAP] programming remains reactive in nature, continuing to individualize problems and to perceive the worker as a problem or troubled employee. EAPs can still be regarded in many ways as a management tool and a form of social control, affecting behaviour on the job and designed to enforce compliance with management-based norms and standards (p. 33).

Personal counselling, CISD, and R2MR, may all be considered reactive in that they address a perceived problem or pathology, rather than the broader context in which those problems occur. Here, Csiernik signals the control employers have over the workplace and how this control is used to define what is normal and what is pathological. In the case of paramedics, high rates of PTSD are an example of a widespread, but individualized problem. Fortunately, in the years that followed the review of Canadian EAPs, employers' obligation to workplace safety has been increasingly scrutinized.

1.4.2 The CSA Standard

Many Canadian employers are willing to address psychological safety, but it is not clear they know how. A 2007 study of Canadian employers (not specific to the emergency service industry) showed that over 80% of employers wanted to address mental health, while only one in four had received any relevant training (Ispos Reid, 2007). In a series of influential papers on Canada's workplace mental health movement, legal scholar Martin Shain warned that Canadian employers could be facing increasing liability for failure to provide or maintain a psychologically safe workplace (2009a, 2009b, 2010). Ultimately, employers carry an implied duty of care and are legally liable where 'reasonably foreseeable risk' to the psychological well-being of employees is present. In order for them to respond appropriately, however, Shain called for a national employment standard to provide guidelines for employers (2009a, 2009b, 2010).

In 2013, following years of collaboration between major stakeholders, the *CSA Standard for Psychological Health and Safety in the Workplace* was published. It details "a systematic approach to develop and sustain a psychologically healthy and safe workplace" including a strong focus on risk mitigation (CSA Group/BNQ, 2018, xi). The 2013 standard was considered the best in the world (Memish et al., 2017), and was updated in 2018. With the creation of a national standard, a shift occurred from targeting injured workers to targeting their work environments (Braynton & Tournier, 2017). The standard called for employers to address how work was organized, how instructions were given, how leaders supported employees, how conflict was resolved, and how people related to each other (Baynton & Fournier, 2017, p. 15). However, while the standard provided specific guidelines, a 2016 study found many employers felt that it being voluntary decreased its priority in the workplace (Kunyk et al., 2016). Historically, mandatory enforcement and regulation have been required to support workplace safety.

1.5 The Employment Relationship and Workplace Safety

The employer-employee relationship rests on a history of tense, opposing views to workplace safety (Stone, 2002). In cases of workplace injury, employers are typically predisposed to consider how individuals have failed to ensure their own health and safety (Stone, 2002). Employers may, for example, dismiss mental distress as the result of personal causes, of poor work-life balance, or of mental illness unaddressed by those too proud to seek help. On the other hand, employees tend to be critical of how employers fail to provide safe working conditions (Stone, 2002). Employees might argue they do not receive enough positive feedback from supervisors, enough rest periods, or enough staff to handle their workload.

The advent of workers' compensations systems in the late 19th century underpins the contemporary employment relationship that favours the employers' interests in terms of

workplace safety. At the turn of the twentieth century, workers were experiencing high rates of industrial accidents and deaths. Employers were regularly losing lawsuits to injured workers. To protect workers from harm and to protect employers from litigation, compensation costs were socialized under workers' compensation models. Employers' duties to compensate injured workers were redirected, to be mediated by the government (Stone, 2002). As a result, workers were much less able to sue employers for injury. Liability lawsuits were significantly reduced and compensation costs were capped in manageable ranges as workers' compensation premiums (Lippel, 2011; Shain, 2009a; Stone, 2002). In response, workplace safety came under government regulation with various acts that developed into what are now commonly known as occupational health and safety acts (OH and S) (Stone, 2002). At present, Workers' Compensation Acts and Occupational Health and Safety Acts continue to exist as complimentary pieces of legislation, addressing compensation and prevention, respectively. Most industrialized countries share this model (Shain, 2009a; Stone, 2002).

Regarding workplace mental health in Canada, work-related mental health has been the subject of scholarly inquiry for decades, gaining considerable momentum in the 1990s when protections against discrimination and harassment were legislated (Braynton & Fournier, 2017). New anti-discrimination and anti-harassment OH and S laws signaled that employers' have a legislated duty to protect employees' psychological well-being, however provisions that outline protective measures for psychological well-being in general, were not written (Shain, 2009a; Lippel, 2011). Employers' duty to protect the psychological well-being of employees is not specific to OH and S and workers' compensation law. Protections can also be seen in human rights legislation, employment standards acts, labour relations law, collective agreements, and common law depending on the jurisdiction (Shain, 2010). Taken together, the collective force of these protections is an employer's duty of care that is *implicit* in the employment contract (Shain, 2010). Still, labour and mental health scholars have suggested that OH and S legislation is the most appropriate means to codify the Canadian employers' duty of care towards psychological health and safety given its preventative mandate and opportunities for enforcement through OH and S fines (Shain, 2009b & 2010).

1.6 Occupational Health and Safety: Canada and Australia

Under current Canadian OH and S law, neither the employer nor the worker are primarily responsible for workplace health and safety. The same model is not used around the world. Since 1974, the U.K. has an explicit *primary duty of care* ascribed to the employer, introduced through the 1974 findings of *The Robens Report*, which focused on the employer's role in managing risks to health and safety given employers' control over the work environment. From The Robens Report, Australian states also instituted a primary duty of care naming the employer primarily responsible for workplace safety. For Australians, "[t]he central duty provisions of OHS [occupational health and safety] legislation places responsibility upon employers to provide for the health and safety of their employees" (Reeve & McCallum, 2011, p. 189). The duty requires employers to "take proactive steps to ensure the safety of employees, and to a high standard" including protecting workers from their own unsafe behaviour through education and training (p. 193).

The adoption of a primary duty of care in occupational health and safety legislation in the early 1980s in Australia did not occur without controversy. There are limits to the responsibility of employers under this model, in which "…the duty of employers to take care for the health and

safety of their employees is qualified by the expression, 'reasonably practical'" (Reeve & McCallum, 2011, p. 193). What is reasonably practical has been brought before Australia's state courts where employers must prove they took all reasonably practicable measures to protect workers' health and safety (Reeve & McCallum, 2011; Shakespeare-Finch, 2007). This burden of proof on Australian employers has produced working conditions that are very different from the Canadian model. It is important to note, however, that even in the absence of a primary duty of care, Canadian employers still owe a duty of care and can face the same type of liability.

Scrutiny of employers' responsibility to psychological health and safety is increasing in both the Australian and the Canadian context (Shain, 2009a; Shain, 2009b; Shakespeare-Finch & Scully, 2008). The burden of proof on Canadian employers to prove they have provided adequate support may not be as severe as their Australian counterparts given Canada's recent political focus on compensation rather than prevention. Many Canadian jurisdictions have introduced presumptive injury clauses for first responders with PTSD (Baynton & Fournier, 2017). The goal of a presumptive injury clause is to presume the existence of a work-related psychological injury, where a diagnosis by a psychiatrist or psychologist exists. Because there is not yet a way to identify a causal link between injuries like PTSD and the workplace, relying on professional diagnosis is thought to reduce the burden of proof on injured workers when they try to access wage-loss benefits and treatment. In 2012, Alberta was the first province to amend its Workers' Compensation Act, adding a presumption of injury clause for first responders suffering from PTSD (Baynton & Fournier, 2017). In 2015, Manitoba took this approach further, offering a presumption for all cases of PTSD regardless of occupation (Baynton & Fournier, 2017). In 2016, Saskatchewan introduced a presumptive clause for all psychological injuries for all occupations (Baynton & Fournier, 2017) making it the most progressive of all Canadian jurisdictions.

While these psychological injury presumptions appear to benefit the injured worker, it is important to recognize that these amendments alleviate the burden of proof, not the burden of injury. In such cases, the injury has already occurred, reinforcing a complaint-based system. Psychological injury presumptions offer no preventative action. Following these amendments, no changes were made to OH and S Acts to legislate the prevention of work-related mental injuries. The employer may suffer an increase in compensation premiums but no OH and S fines and no further accountability for the psychosocial hazards present in the workplace. Meanwhile, focus remains on the trauma first responders face on the job and on mental health as a personal responsibility rather than how workers are treated by employers and governments.

1.7 A Neoliberal View of Mental Health

The argument over whether work-related mental injury is primarily a pathological, personal problem or the by-product of working conditions is rooted in a neoliberal ideology that pervades many contemporary workplaces. Here, I draw on Esposito and Perez's (2014) view that "[n]eoliberalism signifies an ensemble of ideological and institutional forces whose primary purpose is to create a social reality where all facets of human life are reduced to economic concerns" (p. 432). Under such a system:

> The individual is the only viable unit of concern and analysis (Esposito, 2011; Giroux, 2008). The idea of "society" is therefore little more than a heap of individuals. What this also suggests is that the private realm [economic

> concerns] is prioritized over the social sphere. That is to say, rather than emphasizing the web of institutional forces and social relations that shape individual's behaviours and decisions, human agency is understood as simply a matter of individual choices and private pursuits (Esposito & Perez, p. 421).

From this perspective, the individual and their mental health, is self-contained rather than part of a larger social network. Consequently, mental health problems are seen as a problem of self-regulation rather than a by-product of the work environment. Individuals are only considered normal and functional when they take personal responsibility for their own problems and mental injuries are considered to be a failure of personal responsibility (Esposito & Perez, 2014). Unsurprisingly, this belief system eliminates the opportunity for supportive posttraumatic growth processes.

Neoliberal approaches to governing the workplace often involve practices like deregulation, privatization, and reduction of funding, leading to resource lags that are not scrutinized for their considerable impact on workers' mental health. When governments and employers chose to reduce spending, it has an impact of the working conditions and the health of frontline workers (Lippel, 2011). A 'survival of the fittest ethic' becomes normalized and distress pathologized. Compassion and solidarity become optional and the social bonds necessary for optimal health (posttraumatic growth) are progressively eroded (Esposito & Perez, 2014). Further, the quality of services provided to the public diminishes (Lippel, 2011).

As described above, EAPs are behavioural interventions that focus on changing a worker's thoughts and behaviours to fit normative patterns of the workplace when unsupportive working conditions can have a stronger impact on mental health. Consistent with this ideology, Drewitz-Chesney (2012) argued that behavioural interventions "place responsibility on paramedics to seek assistance, removing accountability from management to foster healthy coping skills and to ensure support from managers and peers in the workplace" (p. 262). The transfer of responsibility from the employer and the government onto the individual is a hallmark of neoliberalism; a process commonly referred to as "responsibilization" (Teghtsoonian, 2009). EAPs are the process by which paramedics take personal responsibility for their ill health while employers simultaneously believe they are covering their liability for employees' well-being.

As part of the responsibilization process, an increase in surveillance measures encourages individuals to monitor themselves and their peers for possible mental health problems (Cosgrove & Karter, 2018). Employers across Canada use Mental Health Commission of Canada (MHCC) branded mental health programs to offer workers tools on how they might manage their mental health (Baynton & Fournier, 2017). The MHCC continuum model of mental health also serves as a self-monitoring tool, as its colour-coded categories for mental states (ranging from green for healthy to red for ill/injured) reduces first responders to a basic level of mental health literacy. Some consider these programs effective in reducing stigma and increasing help-seeking behaviour but ultimately, workers take on the additional responsibility of self-monitoring and self-regulating their distress, regardless of ever-present psychosocial risk factors.

Responsibilization is particularly insidious for first responders because their psychological injuries can easily be attributed to the traumatic nature of their work. Attention is diverting away from the employers' responsibility for managing working conditions and away from the governments' responsibility to regulate workplace safety. When a paramedic develops

PTSD or dies by suicide, the dominant culture narrative is one where they failed to protect their own mental health rather than having suffered an under-regulated work environment or a difficult compensation system. This is often described as a reliance on individual solutions to solve social problems (Cosgrove & Karter, 2018; Esposito & Perez, 2014; Teghtsoonian, 2009).

In the midst of mental health becoming a "growing tide of liability," for Canadian employers, Canadians are currently experiencing a "profound and progressive evolution of the employment relationship," that presents workers with opportunity to affect significant change in their favour (Shain, 2009a, p. 45). Public policy interventions must move away from remedial action and towards preventative measures, a shift that is best suited for the OH and S framework (Shain, 2009a). After-the-fact behavioural interventions for first responders who have already fallen ill are simply not enough. The distress and loss of life experienced by Canadian paramedics (and first responders more broadly) is symptomatic of a neoliberal employment relationship that responsibilizes workers for their distress rather than normalizing distress as part of their posttraumatic growth. The solution lies in holding employers primarily responsible for preventing psychological injuries through occupational health and safety legislation, as well as providing more robust frameworks for supporting workers' mental health. General provisions for the protection of psychological health and safety are long overdue.

1.8 Outline of the Thesis

In this thesis, I examine two different models of supporting paramedics, one Canadian and one Australian EAP, along with their respective workplace safety and injury legislation. The first case study is Medavie Health Services, a private paramedic service operating in Saskatoon, Saskatchewan, Canada. The Saskatchewan model is a complaint-based model that relies heavily on the workers' compensation system to care for injured workers. The second case study is the Queensland Ambulance Service, a public paramedic service that operates in Brisbane, Queensland, Australia. Under this model, the employer is primarily responsible for the prevention of work-related injuries under more equitable occupational health and safety legislation. I argue that this primary duty of care model is a better way to support paramedics because it mandates a comprehensive EAP that must offer interventions above and beyond standard behavioural approaches.

After this introduction, Chapter Two and Chapter Three explain my narrative-based methodology and case selection. In the analysis that follows, I draw on interviews with Medavie paramedics (Saskatoon, Canada), and Queensland Ambulance Service paramedics (Brisbane, Australia), to explore how frontline paramedics participate in each labour system. The analysis is divided into five chapters. Chapter Four explores paramedic culture in a global context. Chapter Five reviews the interventions being offered in the Saskatoon case, along with paramedics' reactions. Again, using the Saskatoon case, Chapter Six looks critically at what asking for help entails in such a culture. In Chapters Seven and Eight, I consider the Queensland case; first the benefit of a prevention focused model, then the lessons learned from a legal challenge to QAS' primary duty of care.

I pay special attention to how each model understands the origin of psychological injury, how responsibility for work-related injury is delegated, and the erosion of social support amidst a race to meet intense demand. Paramedics' own narratives provide insights into how different formulations of occupational health and safety regulation and compensation affect mental health

outcomes for paramedics. I discuss these concepts in the context of the underlying neoliberal ideology that dominates the contemporary workplace. I conclude that there is much to be learned from the Queensland model that demonstrates a better balance of responsibility, with the employer appropriately bearing a heavier burden than the worker. Narratives from paramedics working under two different labour models explain the value of holding employers responsible for protecting the time and space paramedics need to support each other in posttraumatic growth.

1.9 Limits and the Scope of the Thesis

This thesis interrogates the first responders' PTSD and suicide crisis through the lens of peer and employee support, focusing on workplace safety and psychological health. This crisis, however, is a multi-faceted problem with a complex array of contributing factors. Although, where appropriate, I generalize statements and concepts to first responders as a whole, this study speaks specifically to paramedics. I did not formally seek out perspectives from other first responder groups such as police, fire, corrections, nurses, social workers, etc. as while these groups may experience similar stresses, each profession experiences a unique culture and context that requires focused, intentional investigation.

I chose to limit the scope of this thesis to the relationship between the employee and the employer only, but it must be noted that this relationship takes place within a network of many actors. I did not analyze the role or history of unions in this relationship even though it is significant and continually evolving, especially where psychological health and safety is concerned. I did not review Canada or Australia's history of labour law and litigation regarding employers' duty to care for employees' general wellbeing. Instead, I focused only on occupational health and safety, workers' compensation, and psychological injuries.

Regarding psychosocial variables, I did not explore the demographic composition or psychosocial histories of these paramedic groups. I also did not address the role of post-secondary institutions in the formation of paramedics' psychosocial development even though post-secondary training is likely integral to paramedic's experience and the establishment of the culture of the workplace. I also did not analyze broader cultural variables such as mainstream media's role in perpetuating the narrative that focuses on the content of trauma work, rather than the needs of workers. I did not analyze the colonial histories of Canada and Australia insofar as these histories contribute significantly to the ill health of these contemporary societies and therefore, the high call volume that is putting many paramedics under increased, ongoing stress. Further, the gendered experience within paramedic culture seems to be significant given paramedics' paramilitary history in Canada, but it is not addressed in this work. Taken together, it is evident that there are many useful sites for further investigation within this field. This thesis takes one approach, but there are many more.

Chapter 2: Methods

The idea for study emerged out of my experience as a frontline social worker in Saskatoon, Saskatchewan. I had become concerned about the effects of a 'work more with less' ethos in my workplace on frontline worker's health. While managing my own work-related mental injury, I had come to understand the structural inequalities that caused ill health for frontline workers. The increase in work-related PTSD and suicide across first responder groups was often presented as a collection of individual tragedies, but I felt that first responder suicides had become a troubling trend that needed to be more fully understood. (For more discussion of my experience and its role in this study, see the epilogue of this thesis).

As an advocate for the use of peer support among first responder groups, I spoke at an international forum for PTSD in Brisbane in 2015. There, I met a member of the Queensland Ambulance Service's (QAS) Priority One team who provided me with a peer-reviewed evaluation of their program. I was interested by QAS' experience of low levels of psychological distress, which they attributed to a staff support model that included a strong peer support component (Scully, 2011; Shakespeare-Finch et al., 2014). I wondered why QAS would offer such a robust program when EAPs in Saskatchewan were much less developed? I was curious about how they were experiencing distress and support and how these experiences were related to the underlying public policy that regulates the employment relationship.

In this chapter, I explain my approach to the literature review, case selection, and data collection. I describe how I designed the interview process in ways that address concerns about conducting research on sensitive topics and experiences. I also define my approach to data analysis, based on constructivist grounded theory (Charmaz, 2006; 2017).

2.1 Literature Review

This research was designed to study the underlying policy environments that support peer support models in two paramedic organizations. I undertook an extensive peer-reviewed, published literature review of approaches to peer support with special attention to peer support models among emergency service organizations. QAS' *Caring for Emergency Service Personnel: Does What We Do Work?*—the document I had received from the Prioiry One team—clearly demonstrated the value of peer support models among paramedics. In order to develop an even broader understanding of the topic, I explored key concepts related to the mental health needs of paramedics. I reviewed literature concerning posttraumatic reactions in emergency service personnel, organizational culture, mental health in the workplace, and the employment relationship in terms of workplace safety. The results of this literature review are described in the introduction of this thesis.

2.2 Case Selection

In order to examine the effects of different policy environments that produce different models of care for workers, I examined one paramedic service with a formal peer support program and one without, namely QAS and the program available to paramedics in Saskatoon. A formal peer support network is one where paramedics also operate in a role of a peer support person (often a trained volunteer), who is designated to respond to other paramedics either at

critical incidents or at the paramedics' request. The QAS arguably has the best-known peer support model namely, Priority One. This is a statewide public service so I chose to interview paramedics in Queensland's largest city: Brisbane. For the second case, I chose Medavie Health Services West in Saskatoon, a private service. Saskatoon has one of Canada's busiest paramedic services in a province active in the discussion of first responders' mental health. Saskatchewan also has both the most recent and most progressive changes to workers' compensation policy (Braynton & Fournier, 2017). At the time of this study, Medavie Saskatoon expressed interest in a formal peer support model but had not yet chosen one. (Case studies are discussed at greater length in the Chapter Three).

While they had different support models, both Brisbane and Saskatoon are rapidly growing cities where the paramedic services experience high call volumes. The realities of colonialism and racism, crystal meth and opioids, poverty and an aging population were shared across both cultures. Despite these similarities, Canada suffered a mental crisis among first responders, while QAS's paramedics seemed much less affected. I undertook case-specific literature review including, for the Brisbane case, Australia's occupational health and safety laws that include an employers' primary duty of care, Australia's workers' compensation system, and relevant litigation. For the Saskatoon case, I conducted a review of Saskatchewan's OH and S law and workers' compensation law. I also conducted a search for Canadian court cases that challenged the employers' duty of care for mental injuries. Results were limited. I found specific cases and broader discussion in the influential reports written by Martin Shain (*Psychological Safety at Work. Emergency of a Corporate and Social Agenda in Canada* (2009), *Stress at Work, Mental Injury and the Law in Canada* (2009) and *Tracking the Perfect Legal Storm: Converging Systems Create Mounting Pressure to Create the Psychologically Safe Workplace* (2010)). Finally, to better understand the Canadian and Australian labour models, I reviewed the history of Commonwealth labour relations where it pertains to injury and employee assistance programs.

2.3 Recruitment

Prior to recruitment, this research project received ethics approval from three review boards; the University of Saskatchewan Research Ethics Board, Queensland Ambulance Service's Research Department and Townsville Hospital and Health Service Human Research Ethics Committee. Once ethics approvals were granted, I set out to interview a minimum of eight on-road participants and a maximum of five key actors from each location. A recruitment email was disseminated to all frontline workers of Medavie Health Services West in Saskatoon as well as Queensland Ambulance Services' Metro North and Metro South (North and South Brisbane). Administrative staff sent out the emails that directed potential participants to contact me directly.

The recruitment processes differed in some ways. In Brisbane (August/September 2017), paramedics initially showed minimal interest in the project. The QAS research department had informed me that recruiting would be difficult because "paramedics are busy people" that were not likely to take time out of their busy lives to attend this study. It was also suggested that because this population was so well-researched, that another research study was likely to go unnoticed in their inboxes. Finally, QAS' busiest day ever occurred during the first week of recruitment. Perhaps for these reasons, recruitment was slow. Only one participant directly responded to the recruitment email therefore snowball sampling was used. With the help of QAS' research department, invitations to participate were extended to selected paramedics, peer support officers (PSOs), Officer-In-Charge (OICs), Acting OICs, and an educator. In the end, nine on-

road paramedics were interviewed. Five additional interviews were conducted with professionals who have or have had significant influence on the creation or management of Priority One since its inception in the early 1990s.

In Saskatoon (February 2018), I used the same recruitment process with Medavie that I used in Brisbane. Interest was high, yielding dozens of interested participants. This seemed to be a reflection of the level of concern members of this workplace had for psychological injury.The first eight participants to express interest were interviewed. Two participants responded to the recruitment email by announcing their participation and the importance of discussing mental health to the rest of Medavie Saskatoon's staff members.

2.4 Data Collection

Overall, I conducted a total of 13 interviews in Saskatoon. Of the 13 Medavie Saskatoon participants, 12 were on-road paramedics and five were key actors that were employees that worked on expanding the existing EAP. Of these five, some were both on-road paramedics and key actors. In Brisbane, I conducted 14 interviews. Of the 14 QAS participants, eight were on-road paramedics and the other six were key actors, with no overlapping roles. "Key actors" includes employers, researchers, managers, psychologists, educators, a policy developer, and a union member.

Because this study included investigation into traumatic experiences, I used Lee's (1993) *Doing Research on Senstive Topics* to help me structure the interview process. According to Lee, a collaborative-style interview between the participant and the researcher will increase comfort for the participant and therefore trustworthiness of information provided. For these reasons, I chose to conduct in-person semi-structured interviews with open-ended questions. Open-ended questions asked in confidential conditions allow participants to thoughtfully reflect then develop and explain the narratives that best represent their experiences. This also allowed particants to discuss the topics they felt were important to them. When participants became passionate, they were encouraged to continue. Surveys would not have allowed for this kind of collaborative style. Observation methods were not considered optimal given the nature of paramedic work and my need for thoughtful, responsive reflection.

To create a semi-structured interview script for on-road paramedics, I used the knowledge I had developed from having reviewed much of the QAS literature and the pertinent peer support literature, along with my former experience as a frontline worker. The same script was used in the interviews in Brisbane and Saskatoon. I formatted questions to be open-ended to encourage reflection and discussion. The semi-structured interview script was divided into three sections: 1) professional role; 2) stress and resilience and; 3) resources and support. The professional role questions allowed for a foundational understanding of paramedic culture. These questions did not directly address mental health. The subsequent two sections of the interview script examined the perceived conflicts and the proposed solutions for paramedics' mental health. I designed broad, open-ended questions to allow participants to explore their own detailed discussion of the proposed topics, eliciting narratives of paramedics' experience of wellness, injury, and stress, as well as the availability and effectiveness of formal and informal support they experienced. See Appendix I for the full interview script.

I also developed targeted scripts for the interviews with key actors to better explore the various roles and influences associated with the dominant narratives concerning paramedics' mental health. Where I interviewed both key actors and on-road paramedics, the semi-structured interview script was used in combinations with targeted questions depending on the participant's specific role. The basis for these targeted questions is also presented in Appendix I. In writing this thesis, each participant was assigned an M or Q if they were from Medavie or QAS, respectively, followed by a number. A table of participant numbers and their corresponding roles is presented in Appendix II.

I sent interview questions to participants in advance so as not to raise any unexpected topics. Lee (1993) explains that offering the interview questions and topics to the participant in advance can increase the participant's comfort level as well as encourage the emergence of other topics important to the participant. This approach gives the participants a better idea of what to expect so as to avoid unwanted recall that causes distress and it allows the participant to contemplate responses in a deliberate fashion, thereby providing an accurate representation of what is disclosed.

Participants were given the option to choose the location of their interview. In Brisbane, all participants chose to be interviewed at their place of work while in Saskatoon, all but two participants chose to be interviewed outside their place of employment. This was perhaps an early indicator of participants' relationships to the topic and the employer. I developed a crisis plan in case a participant required emotional support. Where a participant experienced distress, I provided them with the option to pause or stop the interview. On one occasion, a participant asked to pause the interview and was accommodated without incident. All participants were offered a list of psychological support services however, none accepted the list. Participants were given the option to have the interviews audio recorded, which nearly all accepted. One participant declined the audio recording and I took notes. Interviews took between one and two hours.

All transcripts were transcribed verbatim and offered to participants for correction and approval. Participants who did not respond to the transcript release requests were notified of predetermined transcript release dates.

2.5 Data Analysis

I chose constructivist grounded theory to structure my data analysis, which was appropriate for the qualitative, critical, reflexive nature of this study. Constructivist grounded theory is a methodological approach, that involves a set of flexible principles and practices that guide the researcher through an iterative, comparative, and inductive process in order to not just describe a phenomenon but also attempt to explain it (Charmaz, 2017). It is well-suited for critical qualitive inquiry because it is a method that builds a critical understanding of the empirical world (Charmaz, 2006; 2017). It is also the most influential research technique for social sciences (Patton, 2002). I used grounded theory to help explain participants' personal experience as it pertains to social phenomena (Hays & Singh, 2012), and to ensure that my findings were grounded in participants' narratives while still recognizing that meaning and relevance is co-constructed with the researcher (Charmaz 2006; 2017).

2.5.1 Qualitative Coding

Qualitative coding of the transcripts was used to discover and organize ideas about the topic directly from participants' narratives. Starting with a specific concept, like paramedics' mental health, I used the coding process to organize the data and identify more complex, interrelated concepts, as described below.

The coding process of ground theory is done in two phases: initial or open coding, then focused coding. The initial coding phase seeks to identify the analytic value of each fragment of the data (Charmaz, 2006). In the intial coding phase, I identified over 30 codes that reflected themes that had emerged in participants' narratives. These codes represented themes like: work/life balance, stigma, help-seeking, call volume, peers and supervisors, stress, PTSD, and suicide, to name a few. These themes could be found, at least to some extent, in every participant's interview, indicating a saturation point had been reached. I used the codes to help me consider similarities and differences across participant narratives. What emerged from this experience was that some codes (or themes) were universal, such as the "suck it up" culture and the difficulty meeting demand while others codes were case specific. For example, where Medavie participants discussed PTSD and suicide, QAS participants discussed concepts pertaining to resilience and posttraumatic growth.

Comparing the intial codes to the information gathered in my literature review, I grouped the intial codes into categories. This is the focused coding stage—creating directive, selective, conceptual categories (Charmaz, 2006). These conceptual categories focused around actors and their relationship with others and their work—as defined by participants. Actors included: the paramedic, partner, crew, supervisor, employer, EAP, government, community, union, media, and post-secondary. Some of the conceptual categories linked actors to concepts including things like: a paramedics' relationship to trauma, individual and employer responsibilities to mental wellbeing, and the burden of mental injury on paramedics and employers. All the initial codes, actors, and conceptual categories are listed in Appendix I. In the final stage of the analysis, I identified key quotations that best represented the conceptual categories that had emerged. I considered the relationships between actors, concepts, and the public policy documents that govern them, particularly, occupational health and safety law and workers' compensation law. I then divided the major conceptual categories in two: prevention and compensation.

2.5.2 Paramedic Narratives

The QAS Brisbane participants told stories with clearly identified narrative elements such as characters, setting, conflict and "moral of the story." For example, when asked about where to access support in the workplace, all participants presented as well-versed on how to access support. Conflicts, like psychological distress, had clearly defined solutions like peer support (formal or informal), resilience, and posttraumatic growth. The dominant conflict in the overall QAS narrative was one of struggle to meet extreme demand, not of a suicide epidemic. This led to me to consider the setting and ask: what underlying conditions had produced a sample of paramedics unconcerned with PTSD and suicide?

The key actors in QAS' staff support program provided narratives consistent with one another, citing the research and conceptual frameworks behind the design of their Priority One program. I had initially centered my thoughts around the idea that PTSD came from the nature of trauma work and individual predisposition. Instead, this group of participants and key actors challenged me to consider the social dimensions of paramedics' mental health. One reference in particular stood out: Firman and Gila's (1997) assertion that it is not the traumatic event that causes disorder, but the lack of empathic connections that follows the trauma. In hearing the narratives of QAS participants, I began to understand these injuries, (primarily PTSD) as broken connections in the paramedics' environment and not self-contained ailments. These key actors also referenced the QAS' legal obligation to paramedics' mental wellbeing by referencing a court case: *Hegarty v. QAS [2007]*. Hegarty, a paramedic who had acquired PTSD in the course of employment with QAS challenged the QAS' duty to care to have protected his mental wellbeing. At this point in the research, the questions of a moral/ethic versus legal obligation to protect paramedics came into view.

Interviews with Medavie paramedics from Saskatoon were emotionally intense and wrought with confusion. Participants had either acquired PTSD or knew someone who had. They either knew, or knew of a paramedic who had died by suicide. The dominant narrative was focused on individual pathology. PTSD and suicide were the top concern in this group, and like the QAS participants, they were also feeling the effects of extreme demand. Identifying the actors was far more complicated than in the Queensland case. Medavie participants signaled the responsibility of the individual paramedic, the employer, and the compensation system most often but also families, unions, post-secondary institutions, the healthcare system, third-party insurance, and the larger public communities in which they operate. The delegation of responsibility varied greatly across actors. Exploring the distribution of responsibility seemed like the most valid theme to analyze further. Instead of *what* ought to be done, or *how,* the conflict in Saskatoon was: *who* ought to be held responsible for paramedics' PTSD and suicide and to what degree?

Research conducted on and with paramedics has suggested that "paramedics have not been asked for their ideas on how to achieve a more supportive work environment, and they may have some of the best suggestions" (Drewitz-Chesney 2012, p. 261). Throughout this process of identifying themes in this research, I noticed a shared concern among Medavie Saskatoon participants for paramedics suffering PTSD and mental distress in general, but also for working conditions. Drewitz-Chesney's call to include paramedics voices [in this crisis] complimented Charmaz' assertion that participants hold "substantial experience, often combined with considerable insight" (2014, p. 27). A theme that emerged that participants provided both expertise and predisposition to problem solving about how to improve their workplace environment.

2.5.3. Findings and Analysis

The findings and analysis that follows is divided into five chapters where I explore five broad concepts: paramedic culture, complaint-based interventions, help-seeking barriers, prevention focused interventions, and the delegation of responsibility for psychological health and safety. Several themes emerged across analyses however each section draws on a more specific set of codes and categories, as follows.

Beginning in Chapter Four, I explore the global context of paramedic culture. I analyze participants' narratives of belonging to a demanding culture well-known for its "suck it up" attitude. In this section, I review several environmental stressors and lay the groundwork for better understanding help-seeking barriers and the need for connection. I discuss the impact of critical incidents and the job as a whole, including the constant need to meet demand and the current climate focused on PTSD and suicide. This section included participants from both case studies.

In Chapter Five, I review the EAP interventions that are offered to Saskatoon paramedics to help them cope with distress. Personal counselling, R2MR, and peer support (informal) are discussed. Paramedics' reactions to these interventions are analyzed for their perceptions of the employer's response to their stress. Lastly, I discuss the employer's perspective on meeting the needs of paramedics while respecting employee privacy.

Still drawing from the Saskatoon case in Chapter Six, I analyze what participants felt constituted significant help-seeking barriers. I used participant narratives to help explain the burden of psychological injury and how it is seen as a personal responsibility. Measures designed to respond to a paramedic who is unable to work and needs more support are discussed, this includes workers' compensation.

In Chapter Seven, I introduce the analysis of the Queensland case. This case offers insight in to preventative measures for psychological injury by focusing on connectedness, resilience, and posttraumatic growth. I analyze participants' perceptions on the value of their formal peer support system. Finally in Chapter Eight, I review a legal case involving a paramedic and the Queensland Ambulance Service. The decisions are discussed while referring to this study's participant narratives that also speak to what reasonable measures for the prevention of psychological injuries ought to entail.

Chapter 3: Case Studies

In this chapter, I describe two case studies of paramedic services. The first, a Canadian service: Saskatoon's privately-owned paramedic service, which is a division of Medavie Health Services West (Medavie Saskatoon). Their developing employee assistance program (EAP) includes: A third party counselling service, third-party benefits that provide for a private counsellor and a psychoeducation program called Road to Mental Readiness (R2MR). The second case is an Australian public service: Brisbane's paramedic service is a branch of the state's Queensland Ambulance Service (QAS Brisbane). Their established, multi-layered employee assistance program, Priority One includes: psycho-educational training for all employees, external and in-house counsellors, a 24-hour counselling line, a robust peer support system, chaplaincy, LGBTQ+ support groups, indigenous support groups and Critical Incident Stress Debriefing (Queensland Ambulance Service, 2018).

3.1 Case I – Medavie Health Services West

Saskatoon, Saskatchewan, Canada

For several years, the City of Saskatoon, a relatively small prairie city of close to 250,000 residents, has been among the fastest growing cities in Canada (Statistics Canada, 2016). The Saskatoon paramedic service is a subsidiary of Medavie Health Services. According to their website, it is a private "health delivery company," owning or managing "ground and air ambulance services, medical communications, clinical training, and [other] community health solutions." It employs 4,300 health care professionals and 6,400 employees in total (Medavie Health Services, 2020). Medavie Saskatoon, one of 11 Medavie subsidiaries, is one of the busiest paramedic services in the country. It employs 174 people, and responds to approximately 30,000 calls a year (Leo, 2020; Medavie Health Services, 2018). Medavie Saskatoon is currently experiencing a significant strain of injured workers; an estimated 10% of Saskatoon paramedics were on leave due to injury during this research project's interviews in 2018 (Participant M11). There are no official measures of PTSD or suicide for this group of paramedics but concern for first responders' mental health in Saskatchewan is marked by several recent first responders' suicides in the province as well as the country.

Paramedics from this service have identified mental health as one of their most significant employment-related concerns. Medavie's health foundation, "an annual social dividend," considers posttraumatic stress (PTS) one of "three areas of particular concern" (Medavie, 2020). In an announcement of a PTS roundtable hosted by Medavie Health Services in February of 2018, Medavie CEO Bernard Lord stated: "We recognize the impact PTS can have on a family and that it's of significant importance for families of military veterans and first responders, including our own first responder families and that of our clients" (Medavie Health Services, 2019). Medavie Health Services West, along with the Government of Saskatchewan, has adopted new policies and programs to respond to the mental health needs of paramedics.

3.1.1 Employee Assistance Program

i. CSA Standard. For further direction on how to address the mental health needs of paramedics, Medavie Health Services adopted *The CSA Standard for Psychological Health and Safety in the Workplace* (2013). Under this standard, a collaborative psychological health and

safety management committee is required in implementing psychological safety measures. The standard encourages collaboration between employees and employers so that the people at risk are active participants in the intervention process. In 2017, Medavie Saskatoon established a mental health committee. At the time that I conducted the interviews for this study, Medavie's EAP consisted of the following interventions:

ii. Counselling. Medavie paramedics in Saskatoon can access Professional Psychologist Counsellors (PPC), a respected local counselling service, used by many other employers working in high-risk professions. PPC —which is paid on retainer—bills the employer directly without disclosing which employee accessed support services or for what reasons, offering workers anonymity. Additionally, Medavie's third-party health insurance and benefits provider, Blue Cross, will cover up to $500 per year in private counselling. Alternative coverage arrangements can be requested directly from Medavie Health Services.

iii. Road to Mental Readiness. In 2017, in collaboration with Medavie Saskatoon's mental health committee, the R2MR course was introduced in Saskatoon. Committee members were R2MR trainers who were certified to deliver the two-day course to their peers. Completing the course was made mandatory for all employers. Course instructors served as connection points to support; a somewhat informal peer support network. One R2MR instruction was made present on every crew.

No formal peer support system was in place however, Medavie Saskatoon and the paramedics' union were interested in developing or adopting a peer support model to continue adding to the program's services. As previously discussed, the CISD model had come under scrutiny in recent years causing many emergency service employers to gradually move away from this model. Medavie Saskatoon has also moved away from the model. Only one participant in this study mentioned a debriefing, and it was sponsored by another agency.

3.1.2 Workers' Compensation

Beyond the employer-provided EAP, if a paramedic has been diagnosed with a work-related psychological injury, he or she can file an injury claim with the Saskatchewan Workers' Compensation Board. In 2016, following similar amendments in neighboring Alberta and Manitoba, Saskatchewan passed an amendment to their Workers' Compensation Act, 2013, providing a psychological injury presumption for all workers and all types of psychological injury (Section 28.1).

3.1.3 Occupational Health and Safety

Where WCB legislation focuses on compensating injury, occupational health and safety legislation is directed at preventing injury. In Saskatchewan, The Occupational Health and Safety Act is dedicated to:

> (i) the promotion of and maintenance of the highest degree of physical, mental, and social well-being of workers; (ii) the prevention among workers of ill health caused by their working conditions, (iii) the protection of workers in their employment from factors adverse to their health, (iv) the placing and maintenance of workers in working

> environments that are adapted to their individual physiological and psychological conditions; (v) the promotion and maintenance of a working environment that is free of harassment. (Government of Saskatchewan, 1993)

The provision of health and safety is covered in the Act's general duties, shared between the employer and the worker. "General duties," under section 3 of the Act, offer that employers shall: "ensure, insofar as is reasonably practicable, the health, safety and welfare at work of all the employers' workers." Similarly, the worker shall: "take reasonable care to protect his or her health and safety and the health and safety of other workers who may be affected by his or her actions or omissions" (Government of Saskatchewan, 1993). The Act contains no definition of health, ill health, mental wellbeing or the psychological conditions referenced in the Act's definition of occupational health and safety, cited above. Beyond these general duties, there are no other provisions specific to the protection of psychological wellbeing.

Expansions to EAPs among emergency service employers, (i.e. the addition of R2MR as seen here) represent a moral and ethical impetus to address first responders' mental health, not so much a legal mandate. In the absence of strong occupational health and safety laws to protect psychological health and safety, the focus remains on the duty to compensate injured workers. Beyond the voluntary CSA Standard, public discussion on governing emergency service employers' liability for psychological injuries is limited, if it exists at all.

3.2 Case II – Priority One, Queensland Ambulance Service

Brisbane, Queensland, Australia

In the late 1980s and early 1990s, Queensland, Australia shifted from a Conservative government that had been in power for 30 years to a new Labour government. Following several multi-casualty incidents, including an ambulance crash that killed a paramedic and a patient, a Parliamentary Inquiry investigated the needs of paramedics in the state. At the recommendation of this Inquiry, 96 separate ambulance services were amalgamated in 1991, into what is now the state-run and statewide Queensland Ambulance Service (Queensland Government, 2019). Recommendations also included the provision of debriefing, peer support, post-incident intervention, counselling and mental health education (Participant Q12). In 1992, in response to these recommendations QAS' staff support service: Priority One was formed as a joint effort between former paramedic and psychology student, Paul Scully; then-student researcher and current scholar, Jane Shakespeare-Finch; and the QAS' first commissioner and former emergency physician, Gerry Fitzgerald. Today, the Queensland Ambulance Service (QAS) is the 4th largest ambulance service in the world (Shakespeare-Finch, 2011) with approximately 5000 employees serving a population of over 4.6 million (Australian Bureau of Statistics, 2011; Queensland Health, 2017).

3.2.1 Employee Assistance Program: Priority One

i. Psycho-Ed: Finding the Silver Lining. The QAS' Priority One mandatory psychoeducation program, *Finding the Silver Lining* includes a reflective journal that is reviewed with a psychologist prior to working on the road. Author, former paramedic, and QAS counsellor, John Murray, focuses on paramedics' inherent resilience and capacity for posttraumatic growth as well as the value of connectedness in maintaining mental health. Posttraumatic stress, rather than

the disorder, is considered to be a natural part in the job and is explored for its potential in personal development rather than simply for its risk of developing into a disorder (Murray, 2016). In my interviews, Participant Q9 explained that rather than focusing on the injury, *Finding the Silver Lining* aims to prevent injury stating that:

> We think it's even more important to be able to educate people before the injury occurs so that they are thinking about that beforehand. And then if they are having treatment then they know this language. It's not new to them.

In this way, paramedics are prepared for posttraumatic growth. Distress and support do not seem unusual or pathological to them.

ii. Peer Support. Priority One's peer support network is one of the largest and possibly most effective peer support models in the world. In its entirety, Priority One has trained over 500 peer support officers (PSOs), peer-elected volunteers who undergo an exhaustive 6-day live-in training course. They are held to a code of conduct, a strict confidentiality agreement and are supervised by clinical professionals (Queensland Ambulance Service, 2018). After a critical incident has occurred, communications supervisors flag the call in an automated system. A PSO is then notified of the incident and calls the attending paramedics to check-in.

iii. Counselling. The Priority One program is run by four internal full-time counsellors but employs 65 external specialist counsellors. The internal counsellors manage the overall program and provide frontline in-person responses for events where a face-to-face response is needed. They individually select the external counsellors based on clinical skill set and fit with the QAS organizational culture. Every year counsellors attend annual workshops hosted by QAS. In addition to providing personal counselling services, these external counsellors respond to the 24- hour counselling line (Queensland Ambulance Service, 2018).

iv. Other Services. In addition to the 24-hours counselling line, Priority One also offers LGBTQ+ Support Groups, a chaplaincy service for spiritual care, and Aboriginal and Torres Straight Islander Employees Support Service that is comprised of specially trained PSO's (Queensland Ambulance Service, 2008).

v. Evaluation. A number of external evaluations of Priority One's comprehensive model have concluded that it is a highly effective EAP (Shakespeare-Finch & Scully, 2008; Shakespeare-Finch et al. 2014). QAS paramedics' subclinical levels of psychological injury have been attributed to the responsiveness of the Priority One model (Scully, 2011). In a 2014 evaluation of Priority One, Shakespeare-Finch et al., concluded that "overall QAS employees had low distress levels and moderately high levels of resilience, workplace belongingness and satisfaction with the services Priority One provides" (n.p.).

3.2.2 Primary Duty of Care

For the people of QAS and Priority One, offering a comprehensive staff support service is a moral and ethical obligation, particularly when operating in a profession where one is routinely exposed to extremely distressful events that leaves paramedics at heightened risk of psychological injury (Murray, 2016). The QAS is also legally obligated to provide such care in order to adhere Queensland's Work Health and Safety Act, 2011. Under the act, *a primary duty*

of care for health and safety of workers falls to the employer. Shakespeare-Finch et al., (2014) explained the employers' obligation: "In addition to the ethical obligation of providing EAP for staff, providing professional support services is an organizational obligation in order to adhere to an increasingly scrutinized provision regarding an employer's duty of care…" (n.p.). The Priority One program is how the QAS meets its legislative responsibility to protect its paramedics. If a paramedic falls ill with a psychological injury, he or she may challenge the employer's duty of care if it is believed that the injury was the result of the employer not meeting its duty of care.

Still, QAS' duty of care was challenged in 2000. In civil court proceedings lasting until 2007, Hegarty, a QAS paramedic, asserted that the QAS was responsible for the psychiatric disorders he had come to suffer from (PTSD and obsessive compulsive disorder) due to QAS' failure to provide adequate support, breaching its responsibility for primary duty of care. The QAS sought to prove that they had taken all reasonable measures necessary to protect Mr. Hegarty's health. The trial considered a number of factors including (but not limited to): the employer's awareness of susceptibility, level of engagement in injury prevention, safety enforcement, available EAP services, and attempts or failures to identify and intervene at signs of dysfunction. In the end, Mr. Hegarty was awarded a settlement when it was determined that the QAS had not adequately trained their supervisors to identify and support distress that resulted in a psychiatric injury (Freckleton, 2008). Following this case, the QAS promptly invested in strengthening its training program for supervisors, which is now a mandatory part of the Priority One program.

After the initial trial, the QAS filed an appeal and won. The appeal court considered two important factors that limit an employer's duty of care. First, employers owe a duty of care to employees' physical and psychological wellbeing, however psychological injuries are far more difficult to prevent due to their personal and complex nature. Second, an employee's right to privacy regarding their health supersedes the employers' duty to intervene—constituting a significant barrier for employers' intervention. In the end, Priority One was deemed a serious attempt to protect employees' psychological well-being. For Priority One's program developers, though, Hegarty's legal challenge left a lasting impact on the importance of taking the EAP seriously.

Chapter 4: Paramedic Culture and Psychological Injury

Paramedicine is a fast-paced and extremely demanding work environment with little room for error. The psychological demands can be extreme and can take a toll. The EMS industry is known for a "suck it up" response to emotions and a "survival of the fittest" work ethic. These aspects of paramedics' work life reflect a tendency to view mental health as an attribute of the individual— something for which they ought to take personal responsibility. Psychological distress is most often considered the result of paramedics' inability to cope with critical incidents on the job (Drewitz-Chesney, 2012; Murray, 2016; Regehr & Millar, 2007). However, following Firman and Gila, "[p]ainful events per se do not cause trauma; it is a break in [or absence of] the empathic connection to others which causes trauma" (1997, p. 98). Participants in this research affirmed this view, rarely, if ever, citing the traumatic nature of paramedic work as a primary source of distress. Instead, they emphasized organizational stressors such as a lack of social support and resourcing, as having a negative impact on their mental health.

In this chapter, I examine the ways that psychological distress has often been framed as a responsibility downloaded to the individual while ignoring important social factors such as missed connections and untenable working conditions. I use narratives from participants in this study to examine the relationship between paramedics and trauma work, particularly in regards to critical incidents, the effects of meeting demand and the resulting erosion of social support. The goal of this section is to validate existing claims that a lack of social support and appropriate resourcing are the more significant variables in how paramedics experience distress in the workplace.

4.1 Response: Suck It Up

Paramedicine is a fascinating field for many because it is uncontrolled, unpredictable, and intense (Murray, 2016). The traumatic nature of this work means making life and death decisions while bearing witness to extreme violence, acute and chronic illness, and devastating unforeseen accidents. It can absolutely overwhelm individual coping mechanisms (Drewitz-Chesney, 2012; Murray, 2016). In our interview, Participant M7 explained that being the difference between life and death is an "overwhelming weight of responsibility." He recalled how confronting this responsibility can be:

> I can still picture this guy. I can picture the house. I can picture everything. We walked in there and he had this look full of impending doom. […] He had this look in his eyes like he didn't have to say a word. He says, 'Help me please. I think I'm dying.' And he was.

This participant then did the math of how often an experience like this might play out over the course of a paramedic's career stating: "Think of how hard that hits you once or twice a shift conservatively, for 360 times a year, 3,600 times in 10 years, 7,200 times in 20 years. It takes its toll." This is a profession that carries extreme and constant responsibility. The toll it takes is often psychological distress that if left unaddressed, can result in injury, disability, even suicide.

Participants working for Medavie felt that the emotional toll of their jobs was a matter of personal responsibility. They explained the expectation to have known what they were getting

into and to be quick to respond to awaiting calls. Participants described the well-known "suck it up" attitude. Participant M7 explained this prevailing view as: "Oh well, just deal with it. Suck it up. Go. We got calls waiting." Participant M9 stated similarly that paramedics are taught to: "Suck it up. Deal with it. You signed up for this. You knew what you were getting into." Participant M4 also described the "just suck it up and do the job" culture as one where "there was no recognizing that this is painful or recognizing that anything was damaging."

The suck-it up approach is so pervasive that Participant M7 explained; "I can't even count how many times I've been told that. You have tears rolling down your cheeks and it's like, 'suck it up, get going.'" Participant M8 explained that, "It's on you to be prepared." She further expressed sadness that this state of affairs did not seem fair stating that: "…it just sucks, it's okay it's all on you and as your company, as the people who dictate your life and that you are giving your life for, [they] are not going to be prepared but you should be prepared…"

This view that psychological distress is a function of the individual—a personal problem—and as such, requires individuals to take personal responsibility for their own distress, reflects a neoliberal approach in which workers are dispensable and their pathologies are their own responsibility. In this way, paramedics are taught to refrain from asking for help and feel as if they are left to manage psychological distress on their own. The individual is to blame when 'sucking it up' fails—so they suppress their distress.

4.2 The Relationship with Trauma

Critical incidents—the calls that cause unusually strong reactions and may impair a paramedic's ability to function (Mitchell, 1983)—include, but are not limited to: the death of a child, multiple casualty incidents, extreme violence, and patients known to the medic (Murray, 2016). In Queensland and many other areas, critical incidents are referred to as "potentially traumatic events." These events can increase psychological distress for paramedics because they challenge a paramedic's worldview and can shake their sense of self (Murray, 2016). Following up with workers (formally or informally) when calls like this occur, is the minimum standard of care happening to varying degrees throughout emergency service workplaces (Hurley, Ferriera, & Pain, 2005). The hour immediately following a critical incident is a particularly sensitive period where check-ins can have the most positive impact (Drewitz-Chesney, 2012; Murray, 2016). Therefore, interventions aimed at critical incidents are important.

The understanding that some calls have more impact than others acknowledges that there will be periods of increased risk to a paramedic's mental health. But focusing only on calls that are *commonly considered* critical incidents is a natural tendency that assumes we know with some certainty which events are going to be more psychologically distressing than others. In fact, it is not fully known exactly which calls are going to adversely affect a paramedic (Drewitz-Chesney, 2012; Murray, 2016). This makes identifying that hour of need much more complicated than simply evaluating the traumatic nature of the call. Participant M5 explained the unique and personal nature of critical incidents:

> For me, having a patient with cancer is a huge reminder of the fact that my dad has cancer and my grandpa has cancer and they're both going through it right now. Or someone that has severe respiratory issues throws me right back to like, "This is where my mom was right before she died." For me, that

> would be a critical incident, but for no one else that would be a critical incident.

This explanation of a critical incident shows how paramedics are unique individuals who relate to their work in unique ways. Highlighting standard critical incidents does not capture an experience like the one described by Participant M5. Perhaps the only way to understand where and when these tough personal connections occur is for supervisors and peers to develop an understanding of each other on a personal level.

Paramedic-supervisors in both Saskatoon and Brisbane accepted the reality that paramedics are personally connected to their work. Supervisors interviewed as part of this study placed a great deal of value on 'knowing their people.' Participant M13, a Medavie supervisor explained that knowing a paramedic on a personal level means knowing a bit about a paramedic's family and personal life. For this supervisor, knowing paramedics at this level helped identify which calls might have more impact than usual and therefore, which paramedics to check in with. Participant Q3, a supervisor from QAS, considered it so important, he would go into work on his days off "just to catch up with 'em" if he is not able to do so during working hours. The value of 'knowing each other' on a personal level in order to better understand which events might be critical for others allows supervisors to be supportive during posttraumatic reactions. It works to counter the "suck it up" culture that focuses on personal responsibility. Unfortunately, understanding the necessity of really knowing one another did not ensure that there was adequate time, space, and personnel to do so. The practice of going into work on time off to get to know crew members suggests sufficient resources are not being provided for supervisors to accomplish this during the time they are paid to work. This then, removes supervisors of a crucial tool in promoting personal growth and managing psychological risk.

4.3 Meeting Demand

For urban paramedics, productivity means a high call volume consisting of an extremely diverse range of time-sensitive calls. At the time of this study, both Medavie Saskatoon and QAS Brisbane were at peak call volumes—a relatively normal occurrence. There was not only a need to meet demand, but to do so at the highest standard, at all times. These calls are often a matter of life and death, and the safety of populations is contingent on trusting that high-quality emergency services are available in times of need. Paramedics have adapted by skillfully working in food and bathroom breaks, including eating while executing maintenance or reporting tasks or en route to a call. These adaptations reflect a workplace that does not fully consider their needs; workers are doing more with less.

Participants in both Brisbane and Saskatoon described this system as "go-go-go" without reprieve, often beyond their scheduled shift. Participant M1 described the state of affairs at Medavie Saskatoon like this:

> We are run incredibly ragged. We don't get breaks. We barely get lunch. Some days, you will go an entire day without having a single break and that includes lunch, and then you get $15 if you miss it. That doesn't mean anything to me because I'm literally not wanting to come back to work tomorrow because I'm exhausted.

Participant Q3, a supervisor from QAS emphasized the effects of this workload on the paramedics in his crew:

> Can you imagine what it's like to go to work and do a 12-hour shift where your employer doesn't even say sorry, just doesn't give you a meal break? And so you pick up something and eat it while you're driving along and you go from one job to another, to another, to another and then when your 12 hours is finished, five minutes before it's finished, they send you on another job because you haven't finished work and that takes you two hours over. And you come the next day. And you're doing day shifts. And you're doing night shifts.

This QAS supervisor warned that this busy-ness is hurting workers and "is going to be even worse later." He claimed that paramedics are getting burned out from being worked much too hard and adds that often, paramedics are wrongfully attributing their stress to personal causes, such as marital discord. He concluded: "I know, through discussion, that it's just the volume of work—they're not getting any breaks." The QAS supervisor did not mention the traumatic nature of paramedics' calls as a source of stress, rather, he identified the organization of the workload as unsustainable for frontline paramedics—something they are confusing with personal stress. The claim that paramedics frequently and wrongfully attribute their stress to personal causes is an example of how psychological distress has been viewed as a self-contained phenomenon has been normalized.

Participants in both Brisbane and Saskatoon viewed regular shift extensions and shifts with not enough vehicles or staff, as highly problematic. Constant pressure was often described in terms of an overwhelming workload, frequent and undesired overtime, and a lack of transition time between calls. Allotting only basic funding, a hallmark of neoliberal workplaces, removes opportunities for the rest and social support between peers and supervisors that is necessary for paramedics to stay healthy and sharp. Murray (2016) explained, "Where the intensity, number, and/or duration of expectations exceed your resourcing, stress levels will be higher which may emotionally and behaviourally manifest as distress" (p. 15). He further explained that "…a *felt* sense of safety and calmness [is needed] so that the sympathetic responses of hyperarousal and hypervigilance are not carried into life beyond [the job]" (p. 52). The absence of this necessary calmness signals a risk to psychological health and safety. Funding cuts result in a lack of recovery time for paramedics, which pose a serious risk for the development of psychological injuries (Shakespeare-Finch & Scully, 2008).

4.4 The Erosion of Social Support

Participants often considered feeling under-resourced and overworked as more damaging than the traumatic nature of the work. Participant Q3 explained the connection between under-resourcing and the erosion of social support: "It's difficult to talk to someone because you are just having to go on the next job." Medavie and QAS participants reliably provided narratives to support the theory that the traumatic events are not as bad as how paramedics are treated following difficult moments. Participant M6 explained it like this: "We lie all the time. We lie that it will be better. We lie that we're okay. And we have to lie so that people can be around us,

which is what causes PTSD." Participant M6 did not blame the traumatic work for causing PTSD but the severed connections to others.

Similarly, Participant M7 described the damage that occurred when an important connection was missed:

> How would I feel if I lost my son? I remember doing CPR on a little kid who's 18 months old and all I saw was my son there. And after the call was done, you get tears rolling down your face in the garage and supervisor comes up and says, "Are you okay?" I just looked at him and I say, "What the fuck do you think? Do I look okay?" "Wow. Well, we got calls. We got to hurry up and go." It's like, "You cold—you frozen cold son of a bitch." "You have no fricking human emotion in you right now." It's all about the money. It's all about the calls. Are you serious to be that cold-hearted to people that are doing this type of job? A job that so few understand and so few could do because of what it does to you.

Participant M7 did not place the source of distress with the call involving a child who reminds him of his son; instead he focused on how his supervisor failed to realize the impact of the call and the opportunity for support and growth. The ability to connect was missed in the name of meeting demand. Participant M7 felt it had happened this way because "it's all about the money." Many paramedics shared this sentiment, signaling the 'business' of this work—one where employees are all replaceable. As Participant Q2 put it:

> Another grad will do the same job. You are a number at the end of the day. And it's quite morbid and it's quite impersonal but it's the same as any other business. If you can replace them; if someone can do the same job… there's 5000 people in the service. There's 1000 Uni graduates every year. I think for the service, if there are any issues, it's easier for them to mitigate it to a micro level. People are dispensable, which is probably the saddest part but it's how I think a lot of businesses are run.

Participant Q2's words describe the priorities of the emergency services industry, and the feeling of being replaceable. Under these conditions, individuals struggle to protect space and time for interpersonal connection and growth and therefore a "survival of the fittest" work ethic thrives.

Participant Q3, the QAS supervisor who used personal time to connect with his crew, offered that supervisors and managers in this industry "don't spend enough time with [our] people. […] They can't see the people. They don't make the time." Severed connections, as described in this section, cause workers to feel undervalued, unsupported, and unheard. Following Regehr and Bober (2005), "…the perceived support of management following difficult situations and the perception that management is sensitive to the needs of workers and their families are associated with low levels of stress, distress and ultimately, disability and job turnover" (p. 50). In the absence of this support, is the risk of a fractured relationship between paramedics and the larger organization, which can significantly impact paramedics' health.

4.5 Summary Remarks

Paramedics perform some of the most demanding work there is. 'Critical incidents' are often highlighted for their potential to overwhelm individual coping mechanisms and cause psychological injury. In the hour immediately after a critical incident, it is particularly important for a paramedic to engage in a supportive connection to promote posttraumatic growth. The ongoing focus on paramedics' relationship to unusually traumatic calls fails to consider the complex social network in which they operate. Understanding the uniqueness of each paramedic and what a critical incident is for them is important in capturing their potential hour of need. Neoliberal approaches to governing the workplace, including minimal resourcing and viewing psychological distress as a personal problem, have resulted in extreme environments devoid of the support necessary to promote posttraumatic growth. In this 'survival of the fittest' reality, workers are encouraged to "suck it up" while they race to meet demands. In ways consistent with existing scholarship, participants in this research articulated that the lack of social support and the business-like attitude of employers caused more distress than the traumatic nature of their work.

Chapter 5: Psychological Intervention – Medavie, Saskatoon

Through EAPs, employers offer a range of services and employees can work to improve their coping skills and adaptability to the workplace. This often seems like a mutually beneficial arrangement (Arthur, 2000; Csiernik, 2005). However, these services consist of behavioural approaches that hold the individual responsible for their own psychological distress; a process of downloading responsibility to individuals known as "responsibilization" common in workplaces governed by neoliberal values (Teghtsoonian, 2009). Promising new mental health initiatives are commodified programs of "expert advice" that are branded, bought, and sold as the remedy for individual ailments. New trends in mental health seek to "empower" individuals to monitor and manage their own mental distress through a series behavioural tasks (Drewitz-Chesney, 2012; Teghtsoonian, 2009) while employers' control over working conditions are kept out of view.

The EAP system is generally thought to adequately cover the employer's legal liability for workers' psychological health and safety. In recent years, however, and for many different reasons, employers have sought to expand their EAP services (Csiernik, 2005; Shakespeare-Finch, 2007). For first responders in the Canadian context, the R2MR approach is a prime example of a more expansive EAP. The new, expert-endorsed, branded behavioural approach appears to offer a solution, yet continues to responsibilize workers through basic self-monitoring practices suggesting that behavioural approaches are not enough to address employee mental health. It is important to note, however, that as employers search for new interventions, their ability to identify those in need is limited by employees' rights to privacy.

In this chapter, I offer an analysis of how Medavie participants perceived their EAP services. This includes discussion of participants' perceptions of their employers' challenges in providing support to paramedics. (The Queensland Ambulance Service approach is discussed in Chapter Six).

5.1 Employee and Family Assistance Plan (EAP)

Historically, Medavie's EAP services consisted of Critical Incident Stress Debriefing (CISD), a third-party counselling service: Professional Psychologists and Counsellors (PPC), and some coverage for private counselling through the Blue Cross benefits plan. Employer sponsored debriefing, that is, CISD, was not mentioned by participants, a reflection of this employer's movement away from that model. Participants in Saskatoon did, however, speak often about PPC. This service offers professional support for personal distress, whether or not it is work-related. Their professional counsellors have specialized training in supporting first responders. Many participants from Medavie West approved of accessing support from PPC. Some participants reported gaining a great deal of support while keeping matters private and separate from the workplace. Participant M4 explained the process and how it was helpful:

> They [Medavie West] do have a policy of, if you need counselling go to these people, we will pay for it. No questions asked. You're a number, it gets submitted as a number, the company never knows that it's you that's there. This particular group, counselling group is really attuned to our needs. I have gone myself. Wonderful. Wonderful group of people— very, very helpful for that immediate crisis moment…

On the other hand, some participants did not like the idea seeking support from someone who had never been a paramedic. Participant M5 described this preference: "I want someone who knows what I've gone through. Like, 'yes, being in that moment is terrifying,' not somebody who's in a cushy office their whole life and heard a million stories."

Similarly, participant M4 offered considerations for how communication is easier with someone from within paramedic culture:

> You don't have to change the language. You don't have to alter your dark humor to make it acceptable, for public consumption or public exposure, right? Even though it's a therapy session, you should be able to say whatever. They often feel like they can't.

A counsellor's cultural awareness plays a significant role in some paramedics' perception of whether or not counselling will be helpful (Interview with Participant Q10). Participants explained how relating through a common language and experience can make a person more comfortable. Accessing professional support from inside or outside of the emergency medical services culture is a matter of preference. This is important because at Medavie, EAP support falls only to a third party outside EMS culture (PPC) and no internal mechanisms for counselling are available, unlike QAS, where professional support is available both within and outside of the organization.

Conventionally, the confidentiality and anonymity of accessing professional counselling through EAP professionals is thought to be a major advantage (Csiernik, 2005). Participant M4 referred to the "no questions asked" policy, which is an advantage if an employee is concerned about how coworkers and the employer might react. However, this design has disadvantages too. First, the EAP system is a *complaint-based system* that relies on the individual to come forward. This means that it is not until an individual has developed a problem and a professional is needed that this system is activated (Csiernik, 2005). No matter where paramedics access services when harm has already occurred (or is ongoing), EAPs serve as largely reactive support systems that do not generally address the need for preventative or social interventions (Arthur, 2000; Csiernik, 2005; Shakespeare-Finch, 2007).

Second, when employers are not privy to which employees access relevant services or for what reasons, the employer does not have access to information that could guide additional interventions to address mental health concerns that originate in the workplace. In such a system, usage rate offers a crude measure of whether mental health concerns are arising, but one could argue that the employer does not receive adequate feedback on the psychological needs of employees (Csiernik, 2005; Shakespeare-Finch, 2007). There is a fundamental need for privacy but employers need more information in order to provide the appropriate services. Further, the outsourcing of mental health support also removes the employer from the position of primary support, which perpetuates the prevailing idea that mental health issues ought to be dealt with by the individual, outside the workplace. Beyond sponsoring this program, employers' participation is limited (Csiernik, 2005).

The use of an EAP third-party counselling service as occurs through PPC in Saskatoon is an example of a behavioural approach to addressing mental health in the workplace. This

intervention seeks to adjust individual behaviour through stress management rather than the addressing the underlying source of stress. EAPs are mostly made up of approaches that encourage workers to self-manage and adapt to the workplace regardless of potentially risky and hazardous working conditions (Arthur, 2000; Csiernik, 2005). Although EAPs are typically presented as mutually beneficial arrangements, they often responsibilize the worker while keeping environmental factors out of view (Arthur, 2000).

5.2 Medavie's Mental Health Committee and Road to Mental Readiness (R2MR)

Expanding EAP services is a move that many employers of first responders have taken in light of the high numbers of psychological injuries and suicides. To move forward, they use the highly regarded Mental Health Commission of Canada (MHCC)'s *CSA Standard for Psychological Health and Safety in the Workplace* (2013/2018). At the recommendation of this standard, Medavie Saskatoon established a mental health committee in 2016. Some participants I interviewed for this study were members of this committee.

Participant M10, a paramedic supervisor and mental health committee member, explained how this committee is developing a new view of mental health: "Our language has changed a little bit. We started to have a discussion around what healthy looks like, and what your responsibilities are, and what you're in control of." She added, "All staff have been at every level, have been empowered to call out themselves and the employees around them if they see certain types of behaviour, and they have been given certain procedures to follow." These statements describe a perception that paramedic culture is changing, while remaining focused on personal responsibility. Empowering the injured to address their personal responsibility to psychological health and safety is a matter of responsibilization (Teghtsoonian, 2009). It falls short of a full view of the problem, namely the influence of the social environment.

Medavie's mental health committee did not entirely fail to recognize the value of the social support network. Participant M10 also signaled the importance of peer connection when she added, "We also encouraged our supervisors to spend some time, which they already are good at, getting to know their staff." The problem is that the value of social connection is easily recognized, but in practice, opportunities are limited. All participants in this study felt the time needed to make supportive connections with coworkers and supervisors was rarely available, which left personal responsibility the predominant focus of relevant interventions.

In 2016, Medavie Saskatoon, in collaboration with the new mental health committee, decided to expand its EAP to include the MHCC's Read to Mental Readiness Program (R2MR). At the time, many other Canadian emergency service organizations had adopted this model. It teaches the mental health continuum;

> The R2MR program provides evidence-based psychoeducation on mental health and stress (i.e. the contemporary Mental Health Continuum Model where mental health spans Healthy, Reacting, Injured, Ill), as well as providing a series of evidence-based cognitive behavioral therapy style skills designed to help participants to manage stress; for example, goal setting, mental rehearsal/visualization, adapted cognitive monitoring (i.e. awareness of self-talk), and arousal management through adapted breathing (i.e. tactical breathing) (Carleton et al. 2018c, p. 510).

By ensuring there is a R2MR accredited paramedic available on each Medavie Saskatoon crew, the goal of the R2MR approach was to reduce stigma and establish a new pathway to support. The purpose was to help paramedics identify and support those in need (Participant M9). Psychoeducation programs, especially with a peer support component, can be fundamental in guiding paramedics through self-regulation and help-seeking behaviours (Murray, 2016).

In terms of R2MR's formal evaluation, Carleton et al., 2018c, noted a "small, but significant" reduction in stigma and improved communication in a municipal police sample. Szeto, Dobson, and Knack (2019) also provided evidence that the course reduces stigma and increases resilience among trainees. It is important to note, however, that reducing stigma and increasing resilience are not synonymous with improved mental health outcomes. With the same police sample which experienced small reductions in stigma and improvements in communication, Carleton et al. (2018c), found "no statistically significant changes in symptoms of depression, anxiety, stress, posttraumatic stress, and alcohol use, at any follow-up time point…" (p. 521). The same study found "…no statistically significant changes in mental health knowledge, resilience, or workplace engagement…" following the use of R2MR (p. 522). These findings became available two years after Medavie had introduced the program in Saskatoon. Even if this program is effective at reducing stigma, reducing stigma does not equate to injury prevention. No measures of posttraumatic growth were discussed.

While R2MR can help destigmatize mental health and teach people how to self-manage (which are independently positive outcomes), the use of the R2MR program as the primary mental health intervention for Medavie shows a clear commitment to ensuring that paramedics are taking primary responsibility for their own mental health by monitoring themselves with a pathologically focused, colour-coded system. R2MR is what critics of neoliberal-oriented mental health practices refer to as expert advice that is branded, commodified, and purchased. R2MR requires individuals to labeltheir own experience, and focuses on the individual's management of stress (without questioning the origin of the stress). Without addressing the extreme environments in which paramedics' psychological injuries occur, the individual is the site of blame if behavioural interventions fail.

The pathological and surveillance-like focus of R2MR points to why paramedics in this study had mixed feelings about the program. Participant M13 described a mixed reaction: "For some of them, I think it has helped. But again […] you should be able to recognize when somebody's having a bad day, to step in." Some participants felt R2MR did not offer new information above what a paramedic ought to already know about mental health. Participant M6 said, "It was a joke, people thought it was a joke," specifically referring to the obviousness of the program's "lessons" and the colour codes it employs to identify distress. Further, for paramedics who felt a stronger sense of urgency about the mental health crisis, the program fell short. Participant M8 questioned the use of R2MR in light of so many suicides: "We have tons of medics across the country for years now, killing themselves and do you think they went to their R2MR peer and called them up? They clearly didn't." In this way, Participant M8 also challenged the notion that those at risk are going to come forward at all.

Beyond the challenges to coming forward and seeking help, it is also crucial to consider the intense responsibility paramedics feel about trying to figure out who among them may be at risk. It is unreasonable that paramedics must "save the public as well as themselves" (Drewitz-

Chesney, 2012, p. 262). Medavie paramedics expressed that they were experiencing significant stress related to the pressure of trying to determine who may need support. Participant M4 described the added responsibility this kind of monitoring puts on coworkers:

> It's eventually going to happen to one of our own and we know it. I know it's going to be somebody that surprises us. It's not gonna be one of these people that's been open about it because their healing has already begun. It's going to be somebody that surprises us. […] If I say something…? Do I not say something? Is this the difference? Is this the conversation that's going to make a difference—between a suicide attempt and a not? Yeah. There's a lot of pressure.

Not only did Participant M4 express how intense this responsibility is—literally another life and death scenario—she does not believe it works. She believes the next suicide, that she considers imminent, will be someone who did not come forward despite the focus in the current climate on encouraging those in need to come forward. Similarly, Participant M5 reported, "… there's not going to be a single person who's in the green zone." This is aligned with peer-reviewed evaluation of the R2MR program that showed no improvements to mental health outcomes.

What emerges from these mixed reactions is a lack of clarity about the employer's role in prevention of mental injury aside from initiating and sponsoring programs such as R2MR. Participant M11 offered that the R2MR program was just a starting point. The R2MR course was one piece of a broader plan that is needed. He stated:

> R2MR at the start of orientation is just one little chunk. It's by no means an end all to be all. But at least it's enough to inform the [paramedics] to say, 'If you need to self-identify, here's what to look for, here's the people you can self-identify to and we will work together.'

Perhaps the practice of inviting injured paramedics to self-identify is also a reflection of the employer's perceived barriers to identify who may need support.

5.3 The Employer's Dilemma

A major barrier for employers is that it is the employee's decision what to share and what to keep private. The employer's ability to directly influence this process is limited in this regard. This can result in the perception that the employer does not care. Encouraging paramedics to come forward could also be a reflection of the employer's limits on approaching an employee with concerns. Participant M8 explained this dilemma of needing a connection with the employer: "I wish that the company had more tools or ways to make you feel […] connected or respected as an individual or respected as a thinking feeling person instead of just a working doing person." Unfortunately, Participant M3 expressed feeling that the company, in fact, does not care:

> I really find it hard to believe that the upper management, that the executive management of Medavie headquarters, is really going to be concerned about mental health and how the workers in Saskatoon are doing. I think they just scooped it [the paramedic service] up because we do a lot of calls and they

> can probably generate a lot of money. I think it's going to become worse before it gets better because like I said, not only are we now private but now we're owned by a remote company. So, I mean, you don't even know these people personally anymore. Like you're not even a person to them; you're a number, right?

Employees do have a right to keep their health matters private, which employers must respect. For example, mandating a psychological assessment for an employee is a violation of workers' human rights (Lippel, 2011). An employer inquiring about an employee's mental health can be perceived as an infringement on their rights to privacy and autonomy over their health care decisions. Participant M11 explained the reality of these limitations using the example of substance abuse:

> I know we have practitioners that resort to unhealthy habits. And more so on the alcohol side. When they are here they are doing their job. Some of them don't have increased absenteeism. So, you really don't have a reason to go confront them. That's kind of a sad thing too, when our society says that everyone has their own right to take care of themselves and their own right to their own health care. The employer is not obligated to know anything. So it makes it really tough as an employer when you want to step-up but an employee can just tell you to pound sand and say, 'No, I'm not telling you nothing.' You get concerned and you want to deal with it but you can't deal with it because they won't tell you anything.

This is a difficult path for employers to navigate. In the current climate, not infringing on an employee's right to privacy can also be interpreted as a failure to intervene—and one that may have significant legal repercussions. For Participant M5, the employers' failure to intervene may be more important than a right to privacy: "I know everyone's like, 'Oh, I don't want to talk about it because I don't want to invade her privacy.' But maybe you should be talking about it, because I didn't even know, […] all of a sudden [an injured worker] fell of the face of the earth." In further discussion, Participant M5 identified the potential legal repercussions of failing to intervene. She stressed the extreme nature of the options at hand:

> Their [the employer's] options are to spend the money to go for it or deal with a giant lawsuit when your family sues you because their kid killed themselves. Those are your options. And it's like, 'Well, we don't have the money to do it.' It's like, 'Find the money to do it or deal with the giant lawsuit, find the million dollars down the road when someone has killed themselves.'

Here, Participant M5 identifies the employer's struggle running a business in an industry that has important implications for people's wellbeing. As what Shain (2010) has called the "rising tide of liability" continues, however, Canadian judges will likely require employers to prove that all reasonable measures were taken to prevent psychological injury. In the following chapter, I explain how the prevailing complaint-based, compensation focused narrative masks this precarious legal climate.

5.4 Summary Remarks

Medavie participants reported positive experiences and perceptions of the EAP third-party counselling service (PPC). Some participants believed they would benefit even more from having access to a counsellor with an emergency response background. Debriefings were not mentioned by participants as an intervention that they were using, perhaps because the employer has moved away from the CISD model given recent debates about its effectiveness. First responder organizations are moving beyond these two approaches—either CISD or third-party counselling services—in search of programs and services that seek to destigmatize and educate workers on psychological health and injury. To improve the scope of available interventions*, The CSA Standard for Psychological Health and Safety in the Workplace* (2018) recommends the employer and employees collaborate through a psychological health and safety management committee. At Medavie Saskatoon, it was through this collaboration that the decision was taken to implement the highly regarded R2MR course. The course teaches paramedics about their mental health and how it falls along a continuum from healthy (green) to ill (red). A series of behavioural suggestions are then given to help employees monitor themselves in order to stay within healthy ranges. Participants in this study were largely unimpressed with the program—equating its teachings to common sense. Peer reviewed evaluation of the program in a police sample did show minor improvements in communication and de-stigmatization but no improvements in mental health outcomes. It would appear that R2MR will suffer the same type of concerns as CISD—effectiveness is limited.

Both interview participants and the existing literature revealed a number of concerns about this current version of Medavie's EAP. More specifically, while EAP services appear to be mutually beneficial, they are actually a series of individualized/behavioural interventions that target individuals' behaviour and not the origin of distress that often stems from organizational factors. The employer sponsors EAP services but in turn, is not required to make changes to the work environment. Whether via a personal counsellor or through the R2MR program, employees are taught to take personal responsibility for stress reactions regardless of the origin of stress. By "empowering" workers to take responsibility for their own mental health, R2MR engages in a tacit form of responsibilization. Workers become responsible for the prevention of psychological injury by monitoring themselves and others with little change to working conditions over which employers have control.

Employers, however, experience barriers to providing more comprehensive services. The confidentiality of the third-party counsellor arrangement is essential because it allows workers to access support without concern for reactions from peers and superiors, but these confidentiality agreements restrict the ability of employers to receive feedback about workplace concerns and stressors. Participants recognized that more needs to be done but that employers' efforts can often be limited by the personal nature of psychological health. Employees have a right to keep their health matters private. Employers can only intervene to a point before intervention starts to look like an infringement on their right to privacy. Unfortunately, the employers' observance of an employee's right to privacy can also be interpreted as a failure to intervene, and by extension, failure to care. This can have serious legal repercussions. Even though all parties recognize that more needs to be done, the solution was unclear beyond further continuing down a path of responsibilization.

Chapter 6: Coming Forward – Medavie, Saskatoon

A common belief in the field of first responders' mental health is that stigma and emotional suppression are to blame for first responders failing to come forward when in need. However, there are several other reasons for why paramedics do not come forward. Programs like R2MR that rely on or empowering injured paramedics to come forward are based on two important assumptions: first, that the injured paramedic is *able* to identify when they have suffered an injury and second, that the environment in which they must ask for help is safe.

Mental disorders can impair a person's judgment and ability to relate to others (Government of Saskatchewan, 2018). This may be one reason why asking psychologically injured workers to come forward and ask for help has been ineffective. It is not that injured paramedics are unwilling to come forward so much as they may be unaware and unable. According to some participants in this study, even in cases where paramedics became aware of their injury through the support of others, the willingness to seek help was also influenced by previous cases where injured workers had been unsupported, isolated, and fired. Previous experience informed a widely felt understanding that the employer did not value individual employees and would easily replace them.

Often, seeking help is not a matter of choice. Injured workers may be forced to seek help when a psychological injury impairs a person's functioning to the point where they can no longer deny the injury. In such cases, workers may apply to the Workers' Compensation Board for income benefits, treatment, and a return to work program. As described above, to relieve the burden of proof on injured workers, the Government of Saskatchewan amended its Workers Compensation Act, 2013, to include a psychological injury presumption clause. Many hoped it would bring much needed relief to psychologically injured workers however, participants in this study explained the ongoing inefficiencies of the WCB system in providing needed support. In this chapter, I examine how many Medavie participants from Saskatoon described the chaotic process of coming forward and its unintended consequences.

6.1 Self-Identifying Need

Simply empowering workers to come forward is an example of responsibilization that does not consider the impairments that restrict the individual's ability to self-identify. As Participant M5 explained, "I think our company's kind of just like, '"Oh, well you should be able to do that stuff on your own.'" In this case "do that stuff on your own" referred to the individual coming forward to access support—a key feature of existing EAP arrangements (Csiernik, 2005). Participant M5 explained why this approach is problematic: "Sometimes you can't, and you're not in the right state of mind because you're so screwed up from what you saw." In his statement, Participant M5 called attention to the level of impairment that psychological distress brings and how this can impact help-seeking behaviours.

Rather than assuming an injured paramedic *can* come forward, it is perhaps more appropriate to consider their ability to self-identify to be impaired. This important consideration is outlined in the Saskatchewan Human Rights Act, 2018, where a mental disorder is considered to impair "judgment; capacity to recognize reality; ability to associate with others; or ability to meet the ordinary demands of life" (Saskatchewan Human Rights Code, 2018, 2 (i.1)). If a

mental disorder impairs a person's ability to recognize reality and associate with others, how would they be able to realize an injury has occurred *and* relate to others in a way to describe it and ask for help? It stands to reason that psychologically injured workers' ability to come forward is often seriously impaired. It is most responsible to conclude that articulating the need for psychological support at the point of injury is a cognitive and psychological task too significant to be left to individual alone.

Participant M6 explained how coming forward happened for her, "I was forced into it," she said. After her doctor noted that she was "unable or unwilling" to admit to PTSD, she recalled, "I had an episode, finally, at work where they talked about the call and everything blacked out and I sweated and I was like, 'I think there's something wrong.'" She recalled knowing people at work were talking about her, and that some of her coworkers advised her that she needed help. Participant M6's story did not include moments of self-realization. Instead, her process was characterized by intense suffering and confusion before peers and loved ones suggested she needed help. The question, as indicated by her doctor, as to whether she was "unable or unwilling" to admit an injury appears to be answered here; she was unable, not unwilling. The difference has important policy implications as effective policy interventions ought to move beyond the dominant discourse that favours the "unwilling" narrative, in order to meet workers in their inability to come forward.

6.2 Assessing the Psychological Safety of the Work Environment

The second assumption underlying existing EAP programs that rely on workers to come forward is that the environment in which they must ask for help is safe. Psychological safety in the workplace is best defined as: "…a state in which every reasonable effort is made to protect the mental health of employees." (Shain 2009, p. 43). In a work environment where psychological issues are highly stigmatized and left to individuals to manage, workers naturally assess what is safe to express in the workplace and what is not. Participant M2 explained how, in practice, this comes down to trust:

> Maybe in a trusted environment you can [come forward with a concern] but then, do you trust your partner enough to be vulnerable with them? Or do you trust your coworkers enough or your management enough that you can show that?

Participant M2 further explained that some paramedics still believe that emotional expression is a sign of personal weakness. She rightfully pointed to the environment for perpetuating this myth and called attention to the value of trusting relationships in the workplace in order to disrupt that mentality. However, as described above, engaging in and maintaining supportive relationships is difficult when call volumes are extreme.

Saskatoon-based participants in this study often assessed the safety of the environment using the cases of other injured workers. Witnessing other paramedics struggle with psychological injuries had the most profound effect on participants' perception of whether or not it was safe to come forward. More than one participant discussed one infamous case. In this case, a veteran paramedic named Tim, lost a patient and a contentious public debate over whether or not he was to blame ensued. Participants observed that Tim's psychological health declined significantly throughout this time. Participant M6 stated: "I truly believe in my heart he had

PTSD." She said the employer (then MD Ambulance) had claimed that they tried to help him but in actuality, she believed "…they railroaded him to the college. [The College of Paramedics] took away his license and they fired him." Participant M5 also described the ordeal:

> The guy was pulling his teeth out by the end of working […] He thought that he was allergic to them, and he thought that he was allergic to everything. These are huge manifestations that he never had when he started this industry, so why wouldn't you look at that and be like, 'This is what happened, maybe we should help him,' instead of being just like, 'Well, he's just crazy, so we'll just let him do his own thing.' I don't think he had any support whatsoever.

For Participants M5 and M6, the lack of support that Tim had suffered was more distressing than other features of the story. The impact of Tim's story highlights a few points. It supports the view that social support is the strongest variable in work-related mental health outcomes. It demonstrates how narratives like this are pronounced in workers' assessments of the psychological safety of the work environment. Finally, it proves that concerns about potentially losing one's job and/or the confidence of coworkers are not unfounded.

6.3 Isolated and Replaceable

When asked what happens when a paramedic comes forward with a psychological injury, Participant M1 stated: "They just kind of disappear and you don't see them again." Other participants shared in this view. Participant M4 referenced the isolation that ensues:

> Once they're off, they are kind of an island onto themselves. They're isolated. I think for the most part, we pretty much leave them alone. […] Because it's still a huge stigma of 'Oh, they're off because they're not coping well.'

Here, Participant M4 demonstrated how the individuals are held uniquely responsible for their mental health outcomes and how regrettably, this causes isolation. The perception that this type of isolation often follows a request for help constitutes a significant help-seeking barrier.

Participant M6, who was off work due to a psychological injury at the time of our interview, explained the consequences of suffering a psychological injury in a work system that undervalues the social reality of mental health stating that:

> No one values me and they're not going to help me, and I know what it is, they don't believe me. And then you get that depression, anxiety, and worthlessness. Boom. Then you get [replaced by] another staff.

The order of Participant M6's narrative is aligned with the view that inadequate social support is the primary source of the injury. First, she doesn't feel valued. Then, she doesn't feel like she is going to get help. She places feeling undervalued and unsupported *before* her psychological injury. Feeling undervalued and replaceable is the opposite of the socioemotional social support that is protective against psychological injuries and constitutes major barriers to help-seeking and posttraumatic growth. It stands to reason that a worker who does not feel valued by their employer is not going to come forward with psychological concerns.

6.4 Stress Leave and Workers' Compensation

Once a paramedic has suffered a psychological injury and can no longer work as a result, medically endorsed stress leaves using sick time and vacation time can cover a short rest period. For some, the rest and time away from work along with support from the third-party PPC counsellors offers a remedy. For others, the rest period is shorter than the time it takes to establish a helping relationship with a mental health professional, develop an individualized plan, implement it, and recover.

If a paramedic has been diagnosed with a work-related psychological injury, they can file an injury claim with the Saskatchewan Workers' Compensation Board (WCB). As described above, in 2016 the Saskatchewan WCB passed an amendment to The Saskatchewan Workers' Compensation Act (2013) providing a rebuttable psychological injury presumption for all workers and all types of psychological injury under Section 28 of the Act. According to their website, the goal of the psychological injury presumption is to "…give the benefit of the doubt to the worker" once a claim for compensation has been made. In other words, "…it is presumed that a worker has sustained the injury as a result of their work unless there is evidence to the contrary" (Workers' Compensation Board of Saskatchewan, 2019). This was an attempt to expedite treatment and improve health outcomes for psychologically injured workers.

Despite the implementation of the psychological injury presumption, a number of important concerns still exist with Saskatchewan WCB's new approach. Participant M5 explained that the overall attitude while adjudicating claims has not changed: "The WCB thing is a giant stress. It's not like that process will ever get any better until they realize that they're dicks with their whole 'I'm trying to prove that this isn't happening to you.'" Participant M6 also explained the frustration that arises from working with the board's lack of preparedness for traumatized workers:

> … At best it's demeaning. At best they have not been given the education and the tools to know how to deal with PTSD. They know how to deal with like a broken leg or whatever but they don't at best know how to [deal with this].

Participant M6 highlights an important problem, that physical injuries and psychological injuries are not the same. The Saskatchewan WCB addressed only physical injuries for almost a full century before expanding to include psychological injuries in 1996 (Lippel, 2011). Addressing psychological injuries under such a system is a complex issue. Participant M6 goes on to explain that the government underestimated the scale of the problem:

> With the presumptive legislation, they thought it was a Band-Aid. I really feel the people that didn't understand [it] were like, "We're going to say this presumptive legislation is going to fix a lot of this problem," when really it is the start of a fix. Now they've just opened the window of the house that's filled with fucking shit, which is not what they thought government-wise.

Participant M6 signals where the new presumption fell short. The new amendment addresses the adjudication process but not treatment or return to work. This means that injured workers will be recognized as injured under the terms of WCB legislation, but the supports they are entitled to are

less clear. Participant M11 was also frustrated with the provincial government's lack of overall direction for psychological injuries despite the new presumptive clause:

> [The Government of Saskatchewan says] they deal with [injured workers] at Workers' Compensation. But they didn't train anyone. They didn't train the intake workers. They didn't train and identify the physicians we need to use. They didn't say, "Oh, the person is in Regina? We're going to set-up video conferencing within 24 hours of a person going off on Workers' Comp as a result of PTSD." No. [Instead] they let them sit at home for months on end until they can get in. […] When the first 4 – 6 months have nothing to do with healing, that's not on the patient. That's on WCB for not getting them into the system.

Timely access to quality practitioners was among the top concerns for Participant M11. He also said, "Worker's Compensation needs to get their act together. It's all fine and dandy to pay practitioners. But the timely access to care is lacking." Delays in treatment can be devastating in cases of severe PTSD where the risk of suicide increases six times and continues to increase the longer it is left untreated (Mental Health Commission of Canada, 2010). Another factor contributing to treatment delays is a troublesome tension that has developed between the third-party insurer (Blue Cross) and the WCB. Often, the third-party insurer will forgo compensation in the view that the WCB will assume responsibility under Section 28. Participant M6 explained the problem:

> If WCB cuts me off—actually, when WCB cuts me off—my doctor would put me on short or long-term disability through Blue Cross but then Blue Cross would be after me. Apparently, they are like: 'We're not paying for that because this is a mental health issue.' And if I go off on Blue Cross then I don't get any RSP from my company anymore. The plan of it for me would be to go back to work until I like couldn't handle anymore however that looked.

Participant M7 had similar concerns:

> It's not diagnosing a broken leg. You're diagnosing something abstract. "We're not paying," that's Blue Cross. "No, we're not paying." That's Worker's Comp. And next thing you know, they lose their house, they lose their spouse. How fair is that for what you've given to society [dealing] with the unreasonable…

The psychological injury presumption was implemented to provide quick intervention for injured workers but it is evident it only governs the adjudication of an injury claim and has no influence over wait times or the quality of treatment provided once the claim has been accepted. Further, WCB's return to work programs are contentious where workers and their employers have felt the worker was forced back to work despite unresolved concerns. For Participant M6, returning to work while still injured is a serious concern and for Participant M7, the alternative to returning to work is devastating loss. These participants expected a struggle, regardless of the presumption. This contentious process is another reason that workers may not want to come forward. For Participant M6, who was off work with PSTD and on WCB's program at the time of

our interview, the response to her psychological injury was inadequate at all levels. Still struggling through recovery after numerous engagements with management, EAP, R2MR and Workers' Comp, this paramedic asked, "Where's my 911?"

6.5 Summary Remarks

Participants described a work environment where the individual is responsible for managing their own psychological injury. The predominant focus of Medavie participants' narratives were on what to do once the injury has occurred. Discussion on prevention was limited. The neoliberal-oriented discourse that seeks to 'empower' workers to come forward assumes that the paramedic is able to identify their own injury and that the social network of the workplace is a safe place to come forward. Seeking help is a far more complex process that includes a number of barriers. Mental disorders, by definition, prevent injured workers from being able to self-identify and relate to others, and participants provided narratives that explained how asking for help was sometimes simply not possible. Participants also explained how they assessed the safety of the workplace regarding matters of psychological injury, including their recollections of injured paramedics who had experienced a lack of support, isolation, and who were even fired. Their experiences supported the general feeling that this workplace was not a safe place to ask for help.

When a worker does come forward with an injury, it falls to the Workers' Compensation Board to compensate and treat the injured worker. Although WCB is intended to be a safety net for injured workers, participants in this study pointed out serious gaps in this system, regardless of new presumptive injury amendments that address psychological injuries. As participants pointed out, the new presumptive clause only addresses the adjudication process, not treatment or return to work arrangements. Further, the WCB process was regarded by Medavie employees as harsh, dismissive, and incompetent, another reason injured workers hesitate on coming forward. The focus on remedy rather than prevention, that is, seeking help once an injury has already occurred, reinforces a complaint-based system that reacts to injury rather than preventing it. It is time the compensation system makes a serious attempt to develop reasonable competency in responding to psychological injuries.

Chapter 7: Connection and Prevention - QAS, Brisbane

As described in the methods chapter above, when I began this study I was in search of a promising peer support model for first responders. In Canada at the time, formal peer support had emerged as a promising practice among emergency service employers yet I had not known of any emergency service that had implemented, maintained, and evaluated a formal model. While in Australia, I met some of the Priority One team who provided me with information on their program. Given the strong peer support component and favourable outcomes, I felt compelled to learn more directly from paramedics themselves.

Since its inception, QAS' EAP Priority One has been comprised of an academic partnership to ensure the use of evidence-based practices, and independent evaluation for continuous improvement. It is a comprehensive, state-wide service for paramedics, dispatchers, and their families that is run by "an internal multidisciplinary counselling unit that consists of a mix of ex-paramedics with psychology and counselling training and highly experienced registered psychologists with extensive first responder experience" (Queensland Ambulance Service, 2018, p. 29). As noted in the discussion of my case selection, the multi-modal program offers multiple proactive and reactive services that include: extensive psycho-educational training for all employees, approximately 65 external counsellors, a 24-hour counselling line, a robust peer support system, chaplaincy, LGBTQ+ support groups, indigenous support groups and Critical Incident Stress Debriefing (Queensland Ambulance Service, 2018).

As opposed to a complaint-based model focused on pathology, the social environment is an important part of QAS' Priority One model. Priority One is grounded in the belief that trauma is the result of severed social connections rather than traumatic events (Firman & Gila, 1997). Posttraumatic stress is considered a normal part of inherent posttraumatic growth processes that produce positive changes following traumatic events (Calhoun & Tedeschi, 2006). Since processing trauma in isolation is where the injury is believed to develop, Priority One offers several connection points in a robust proactive effort to normalize stress reactions, promote a sense of belonging, and reduce the risk of isolation. As such, promoting social connection becomes psychological injury prevention. The strong focus on social connection and posttraumatic growth is supported by the employer's serious investment into a range of services. The arrangement opposes dominant pathology-centered discourse that responsibilizes workers for their distress and dismissed the need for compassion and connection. In this section, I discuss Priority One's unique approach using QAS' participants' narratives regarding the supportive nature of this workplace.

7.1 Salutogenesis and Connectedness

Priority One's model of care is a salutogenic approach to health; focusing on the origins of health and the factors that support well-being rather than pathogenesis—the factors that produce disease and ill health (Antonovksy, 1996). Salutogenesis accepts posttraumatic stress as normal insofar as "this approach removes the perceived pathology often associated with trauma and instead enables people to consider early adaptive coping strategies and recognize that an acute stress reaction can occur as the result of the brain acting normally" (Queensland Ambulance Service, 2009). In the QAS psychoeducational training manual *Finding the Silver Lining*, paramedics' psychological well-being is discussed in terms of the inherent resilience they

possess and the posttraumatic growth processes they undergo as the result of repeated exposure to trauma. Participant Q10 explained why the salutogenic approach is preferable and how pathogenic models fail:

> Systems that focus on PTSD pathologize almost any stress reaction. [Therefore people who may] have a normal posttraumatic stress reaction [are likely to think], "Oh shit, I'm going to get PTSD," and they are fearful of that so they lock it down. They avoid it. They suppress it. And we know that just comes out later on in some other ways. […] If your focus is on PTSD, you've missed the boat. You're dealing with the people who've already been badly injured.

Participant Q10's words speak to the value of preventing injuries rather than reacting to them. He calls attention to how emotional suppression in a pathogenic model is fear based. It is rooted in the fear of losing integral social connections when marked by a psychological injury in an industry where normal stress reactions are highly stigmatized. Normalizing stress responses and enhancing connection are a critical method of health promotion and injury prevention.

Social support is perhaps the most important variable in paramedics' mental health (Drewitz-Chesney, 2012; Regehr & Millar, 2007; Shakespeare-Finch, 2007). Priority One's salutogenic foundation is well-suited to the use of social connection to promote psychological well-being and reduce the risk of injury. Priority One seeks to promote "connectedness" —the number and quality of social relationships in the workplace (Murray, 2016). Participant Q4 explained:

> Making sure your mental health is good—there's where Priority One works quite hard on making sure we all have connectedness because without it you start to feel that loneliness and the real sour taste of work. We all have those mornings where you just don't want to put your shirt on. All in all, I think that a very important thing, that we look after each other's and our own mental health.

Here, Participant Q4 described the sense of connectedness that Priority One is designed to achieve. To do so, staff at every level undergo comprehensive psychoeducational training on posttraumatic stress, resilience, and posttraumatic growth. From there, Priority One offers several connection points to support. While there are a number of available support services, the peer support model and supervisor training are especially attuned to enhancing connectedness on the job (Queensland Ambulance Service, 2018). All paramedics are trained in how to process trauma in resilient ways that lead to personal growth but in addition to this, their peers and supervisors are encouraged to attend to them and provide referrals as needed. In this way, the real source of injury, the lack of connection to others, is removed and stress can be diffused from the first point of contact.

7.2 Priority One – "The First Call"

In a series of focus groups studying the perceived effectiveness of Priority One, Shakespeare-Finch and Scully (2008) found that "… the overall EAP and each of the services the program provides are highly utilized and highly regarded by staff (p. 85). Their findings are consistent with the views of my interview participants who typically viewed the program as

credible and inclusive of comprehensive avenues for support. Participant Q8 identified Priority One as "the first call" if her personal supports failed in any way. Participant Q7 explained, "It's nice to know that their umbrella is cast really wide. We're covered not matter what… You feel supported with that. It gives you an extra barrier of armour that you can rely on." Participant Q1 called specific attention to Priority One's accessibility: "I think it's actually so easily accessible it's unreal. All the information that you need." The result was a general consensus that a supportive workplace exists. Participant Q5 described what support looks like among QAS staff: 'It's somebody asking you how you feel and helping you to make sense of something that maybe doesn't make sense." Participant Q1, who had been floating to different stations for shifts at the time of our interview, noticed that this is not an isolated occurrence. At all the stations he worked at, he was able to connect with his peers: "Once you get to know everyone in the area, everyone's pretty nice and supportive. You can probably talk to most people. […] In general, everyone's really supportive." Participants' view of their support system suggested that employees *felt* a sense of safety.

From the perspective of paramedic supervisors I interviewed, Priority One was seen as indispensable in supporting the psychological needs of a paramedic crew but also as a defining feature of the employer-employee relationship. Participant Q5, a QAS supervisor explained:

> [Priority One is] probably the thing I go to the most. […] I think it shows that as an employer, the QAS is supportive of their people whether it is a workplace related issue or not. I'm a big advocate for the employee assistance program.

This participant credits the employer for using Priority One to show they value their employees. Participant Q14 said something similar: "There is no doubt in my mind that the organization is serious about supporting staff. And there's no doubt in my mind through the commitment to Priority One that the organization wants to promote and protect that." This underlying supportive message from the employer is intentional to show that the employer is willing to share the responsibility of psychological health and safety. It is most apparent in the peer support network.

7.3 The Peer Support Model – "The First Line of Support"

Across the state of Queensland, hundreds of specially trained and supervised Peer Support Officers (PSOs) serve the close to 5000 QAS paramedics (Queensland Ambulance Service, 2018; Queensland Health, 2017). PSOs are specially selected volunteers that "undertake ongoing training and supervision in mental health and awareness and in specific support and micro counseling skills" (Queensland Ambulance Service, 2018, p. 4). They must come recommended by their peers and they take an oath of confidentiality. Their training spans a six-day live-in psychoeducation and peer support training program. PSOs aim to help "diffuse matters" before they escalate (Queensland Ambulance Service, 2018). Where matters are not diffused, PSOs "facilitate quick access" to other support services such as trained counselors; internal or external to the QAS. This "minimizes the likelihood of complications [and potentially] psychological injury…" for paramedics (Queensland Ambulance Service, 2018, p. 5). By design, peer support connections promote the connectedness necessary in ensuring psychological wellbeing and in turn, preventing injury.

In interviews with participants working at QAS, the peer support model was so often mentioned that it almost seemed synonymous with the broader Priority One program. Participant

Q7 told a story about how the peer support model works. He and a student partner responded to a person who had died by "train-surfing" on Brisbane's train network. While hanging on to one train, the victim was struck by another going in the opposite direction. The scene was gruesome and this participant was comforted by the expectation than Priority One would follow-up with the young paramedic after the team had informally debriefed and check-in following the call. He concluded his recollection with, "Everything was ok in the end but it was really nice for peer support to call us as well, like the mentors as well and make sure that we were ok." Participant Q7 also considered the PSO service, and by extension, Priority One, to be reliable and protective, "an extra barrier of armour that you can rely on." In this statement, the armour that Participant Q7 referred to is a preventative mechanism, protecting against potential psychological distress and injury. Similarly, regarding a PSO check-in, Participant Q8 said, "It's nice to know that someone was looking out for you. Even though I was ok, I might not have been." Feeling valued, as these paramedics described, is part of the connectedness Priority One seeks to achieve. In fact, for most participants, the assumption that a PSO will check in with them after difficult calls seemed more valuable than the content of the check-in itself.

7.4 Support Among Peers and Supervisors

Beyond engaging in formal support mechanisms, participants also spoke of providing informal support to others. Participant Q8 explained how offering support fuels connection and serves to prevent mental breakdown:

> I've definitely asked other people if they were okay, as people have asked me if I'm okay. I like to make a point. It's not that I'm afraid that I'm going to have a mental breakdown, I just see that it can happen and so I don't want it to happen. It can impact on the rest of your life. Forever. I would like to avoid that. I would like it to be avoided for everyone. I like to make a point of asking someone if they are ok after a big job. Even if it's someone who is of a higher level than me. […] Just going, "You alright after that job?" Even if they just go, "Ah! Of course!"[…] Because maybe afterwards they go, "Ah, that was nice."

Participant Q8 spoke of using social support to prevent mental breakdown. She also addressed how severe psychological injury can be when she points out that such injuries can impact the rest of a person's life. And finally, she explained how, even if a paramedic does not need a check-in per se, checking in with someone still promotes a sense of being valued. It may sound simple, but a supportive environment of this kind can be effective in ensuring psychological safety. And the support goes both ways. QAS participants also favourably discussed their supervisors' ability to support and triage mental health related concerns appropriately. Participant Q8 felt adequately supported by QAS' supervisors:

> If I messaged [my supervisor], telling him I'm a bit stressed about... not even a job, but like a conflict between a staff member or whatever or at the hospital with a hospital staff member, they understand as well. Obviously there has to be the professional boundaries between manager and paramedic but for the most part everyone's like, "Aw, we'll go and get a coffee. We'll go talk about it. […] I would say that for every single [supervisor] I've had at this station… they're all approachable and that's what you want in

> someone who's your boss. You don't want to be afraid to walk into their office. Or if they call you into their office, you don't want to be scared of what they are going to say. That helps with stress…

Viewing peers and supervisors as supportive is an important aspect of a supportive work environment committed to preventative interventions (Cadieux & Marchard, 2014; CSA Group/BNQ, 2018; Regehr & Millar, 2007). The fears of interpersonal conflict, stigma and job loss as expressed by participants working for Medavie in Saskatoon, was simply not present in the narratives of participants working for QAS. The QAS' focus on social connectedness seemed to reduce situations in which such fears occur. Paramedics felt that they were part of a team, and not responsibilized for psychological distress. Healthy, supportive work environments work to mitigate risk of mental injury where bonds between workers are strengthened.

7.5 PTSD and Suicide versus Unavoidable Posttraumatic Stress

QAS paramedics are not only satisfied with Priority One's services; they demonstrate low levels of psychological distress—including PTSD and suicide (Shakespeare-Finch et al., 2014). Rates of PTSD and suicide are lower than the general Australian population (Scully, 2011). QAS paramedic-participants that I interviewed offered limited discussion of PTSD and suicide, but did express general approval for Priority One. Participant Q7 did not think suicide was "super high on the radar" and explained that work-related suicide "is not a general topic of conversation." Participant Q2 expressed that suicide is "not really talked about too much because it's not something that really happens. It's not like it's a rampant issue that's happening or has happened a number of times." These statements reflect the view that PTSD and suicide are not a significant issue of concern in the QAS workplace.

Although PTSD and suicide were not important topics of conversation, QAS participants described posttraumatic stress as "unavoidable," and "just part of the job" (Participant Q2) but that it is easily managed in a supportive social network. In a multi-method peer-reviewed evaluation of Priority One, Shakespeare-Finch and Scully (2004), addressed the effectiveness of Priority One:

> Perhaps some of the reason this EAP is held in such high regard generally is due to (1) its attempts to view the individual in context, providing support to the staff member and their families, (2) offering support via a number of distinct avenues, (3) support is given both with and external to the organization, (4) the EAP is supported by personnel, by the organization, and by organizational hierarchy and (5) the program is committed to continual improvement. (p. 88)

Priority One's effectiveness versus the distress experienced by Medavie participants was the most striking difference between the two paramedic case studies. While Medavie participants expressed considerable distress over low levels of support, QAS participants showed minimal concern for psychological injury and well-developed strategies regarding how to process posttraumatic stress and ask for help if needed.

7.6 Summary Remarks

QAS paramedics who I interviewed provided narratives consistent with existing research findings; they experience low levels of distress and are satisfied with support services, especially the peer support model that aims to diffuse matters before they escalate. Participants readily discussed posttraumatic stress, resilience, and posttraumatic growth and were not very concerned with PTSD and suicide. Their lack of concern with PTSD and suicide is likely attributable to Priority One's salutogenic model of care, which focuses on connectedness by providing staff with several sources of social support throughout the workplace network. By recognizing that psychological injury stems from severed connections to others rather than the traumatic event itself, paramedics are trained to work through processes of innate resilience and posttraumatic growth with each other rather than simply guarding against injury as individuals. This model promoted a balance of responsibility between individuals and the organization in which they operate. Some participants viewed Priority One as evidence that their employer cares for their well-being.

Chapter 8: QAS, Brisbane – Not Without Its Challenges

By actively promoting connectedness and posttraumatic growth in the workplace—the QAS' Priority One program takes primary responsibility for the wellbeing of its workers. Where the employer has taken a stronger role in supporting employees' mental health, the burden on individual workers has decreased, and there is less risk of responsibilization. This is an example of a highly effective EAP that fulfills the employer's legal obligation to care for the psychological well-being of employees.

Under the Australian *primary duty of care*, the employer is held primarily responsible for occupational health and safety. Employers are to assertively engage their psychological safety measures especially where first responders naturally carry a foreseeable risk of psychological injury (Freckleton, 2008). The QAS' legal obligation to address psychological health and safety was challenged in the early 2000s, when former QAS paramedic Robert Hegarty sought damages for QAS' alleged negligence and breach of statutory contract. Mr. Hegarty asserted that the PTSD and obsessive-compulsive disorder he suffered was the result of the QAS' failure to meet their primary duty of care. The judgment at trial found in favour of Hegarty, determining that the QAS had failed to adequately train supervisors to detect signs of dysfunction. However, on appeal, the judgment found in favour of the QAS, with the decision calling attention to the factors that limit an employers' duty of care.

Freckleton's 2008 case commentary, *Employers Duties for Reasonably Foreseeable Psychiatric Injury: Hagerty v Queensland Ambulance Service [2007] QCA 366,* reviews the key concepts of the initial trial and the appeal. In this chapter, using Freckleton's case commentary, I highlight the key arguments that can also be seen in narratives provided by participants in this study. Further, I discuss an ongoing concern to paramedics' mental health not addressed in these trials, namely the threat of excessive workload demands to paramedics' health and the broader employment relationship.

8.1 The Primary Duty of Care and First Responders

Under Queensland's Work Health and Safety Act (2011), the employer holds the *primary duty of care* for the health and safety of the workplace. The rationale is that the employer, rather than the employees, holds the most power over workplace conditions (Reeve & McCallum, 2011). Regarding this duty of care, two important qualifications emerged prior to the Hegarty case. First, the employer's duty of care is dependent on the level of foreseeable risk to employees. In Australian jurisprudence, a first responder's exposure to trauma is considered sufficient for "readily foreseeable risk" of psychiatric injury (Freckleton, 2008). The second qualification to an employer's duty of care is that employers are not to skirt around this duty. In a 2007 case (*New South Wales v Fahy* [2007]) that had addressed psychological injuries among police officers, the decision read:

> The system must be enforced. This must be done even against employee resistance. […] where the employer becomes aware that there is such susceptibility, or should be aware in the ordinary course of reasonable conduct, special precautions need to be taken [by the employer] to fulfill the duty of care that is inherent in the employment relationship (at [103]).

This requirement arose in the Hegarty case as well. It had a lasting impact on QAS and Priority One. Key actors I interviewed from Priority One referenced this legal requirement to be proactive when they spoke about Priority One's purpose. Participant Q9 explained it like this:

> [The Hegarty Case] a few years ago did mention that it's not just enough to have a staff support service in place, it has to be proactively engaged. So a lot of what we do…we can't stop. We keep pushing every day, providing as much education as possible, continuing to do what we do. It must be *assertively engaged*…

Similarly, Participant Q11 explained that you cannot change the reality that paramedics will be exposed to critical incidents or potentially traumatic events. In her view, the primary duty of care means the employer must "constantly be in the face of paramedics" about the services that will help normalize their stress reactions instead of "shoving it under the carpet." In other words, under the Queensland model, foreseeable risk of mental injury for first responders has been established. Mitigating this risk means *assertively* providing preventative services. Anything less and employers may be held liable.

8.2 Hegarty and the Chance of a Better Outcome

Hegarty v. QAS examined what constitutes a reasonable response from the employer as given that there is a foreseeable risk of psychological injury for paramedics, and that employers need to assertively provide preventative services. Hegarty's legal team claimed that the Priority One training was not adequate because it relied on the injured paramedic to self-identify. Although Hegarty had been trained through Priority One, the argument was that "this training was inadequate because a stressed person may not recognize in himself or herself symptoms of stress that require treatment" (Freckleton, 2008, p. 20).

The idea is that no amount of training is adequate because the nature of psychological injury makes self-identification an unreasonable request, is an important critique of mental health support programs that rely on self-identification. This was identified by Medavie Saskatoon Participant M5 who explained, "…you're not in the right state of mind [to ask for help] because you're so screwed up from what you saw." It is what Participant M6's doctor was referring to when she considered whether her patient was either "unwilling or unable" to admit an injury. It is also why the Saskatchewan Human Rights Code (2018) considers a mental disorder to alter perceptions of reality and cause impaired judgment. For these reasons, empowering workers to come forward will never have the desired preventative effect on injury rates.

Accepting the claim that self-identification is an unreasonable task, the trial in *Hegarty* focused on whether or not QAS supervisors had been adequately trained to identify signs of dysfunction in subordinates. The QAS argued that even the best supervisor training would not allow for every injured employee to be identified and that even when identified, not all injured employees will accept help. Regardless, the initial trial decision concluded that adequate supervisor training would have created *the chance of a better outcome* by further mitigating risk. The logic was that if supervisors can better identify those in need, then psychological injury would become less likely or perhaps would occur to a lesser extent. Hegarty was awarded damages at trial (Freckleton, 2008).

In response to the *Hegarty* trial, QAS' Priority One developed a then-new training program to help supervisors better identify paramedics in need of support (Queensland Ambulance Service, 2009). This supervisor training works to alleviate the pressure on workers to self-identify and promotes a better balance of responsibility for psychological safety in the workplace. Priority One is now held as the gold standard of employee support programs in Australia (Participant Q11). As described in the previous chapter, QAS' participants largely viewed their supervisors as sources of support.

8.3 QAS' Appeal

The Queensland Ambulance Service appealed the trial judgment. At appeal, there were three concurring decisions that reiterated employers' duty to take all reasonable steps to ensure a safe workplace, but also stated that Mr. Hegarty had not showed unequivocal signs of dysfunction. The appeal asserted that Priority One had made a serious attempt to avoid employee injury, thereby meeting the employer's statutory obligation to care for employees' mental wellbeing (Freckleton, 2008).

An important consideration in this decision was the difference between assessing physical versus psychological risk. While the employer has the same duty of care to psychological health as it does to physical health, there are more difficulties in judging the duty of care for psychological health. Psychological injuries are less obvious and more personal. To this end, Justice Keane acknowledged in his judgment that, "…the vagaries and ambiguities of human experience and comprehension must be important considerations that discharge the employer of their duty" [at 40]. As such, the protection of employees' rights to privacy was deemed a limiting factor to the employer's duty to care (Freckleton, 2008). The major contribution of the *Hegarty* decision occurred when Justice Keane stated that "… the dignity, autonomy, and privacy rights of employees are not to be invaded by the imposition of a duty upon employers to intervene unduly when to do so would unacceptably intrude upon employees' personal lives" (Freckleton, 2008, pp. 23 – 24). Essentially, the employer's duty to intervene is superseded by an employee's right to privacy. The employer might want to do more but sometimes they cannot. The need to balance privacy and intervention is a structural problem as much as it is a cultural one, and is experienced in both the case of QAS and Medavie.

8.4 Meeting Demand

One important consideration not addressed in the *Hegarty* case is employers' responsibility for excessive workload demands. Despite the efficacy of the Priority One model and the improvements brought about by the *Hegarty* case, QAS paramedics and Priority One still face serious challenges in this regard. As noted in the methods chapter above, at the time I was recruiting participants for this study, QAS experienced its busiest day to date. Priority One cannot address all areas where paramedics' responsibility is increasing. The challenge of meeting demand for paramedic services is outside the scope of Priority One, but still affects employees' psychological health. Priority One's struggle to meet demand *may* be increasing as well.

The effects of under-resourcing on the frontline workers were best expressed by Participant Q5, a veteran paramedic who said: "They don't wear their pajamas on night shift anymore," referencing the around-the-clock nature of responding to those in need. Participant Q3

further explained how this affects connectedness in the workplace: "Things get missed. Follow-ups don't happen. And although we say we try the best that we can all the time, sometimes, […] we're too busy." QAS participants were clear, that the workload and lack of resources was overwhelming, particularly in terms of available ambulances and overtime hours. Participant Q4 assumed that the effects of the workload were common knowledge:

> Where you've heard about our workload, the lack of resources is telling. We are going to have short careers if it doesn't get good soon. It's draining and people are getting sick. People get sick and are calling us—we're getting sick and have less staff. It's really turned into a nightmare.

Here, this nightmare of racing to meet demand was clearly cited as a reason people are getting sick. Participants commonly blamed mandatory overtime and untenable workloads for interfering with their ability to maintain their health.

Racing to meet demand is a hallmark of a neoliberal approach to governing the workplace that prioritizes economic concerns over employee well-being. For participants, the ongoing experience of being under-resourced carries an underlying message that the employer does not care about their employees, and that employees are replaceable. Participant Q2 explained this impersonal side of the business:

> It is a business at the end of the day. If someone gets a little asterisk next to their name because they are a difficult employee, they could get someone to do the same job. Another grad will do the same job. You are a number at the end of the day. And it's quite morbid and it's quite impersonal but it's the same as any other business if you can replace them.

Feeling like "[y]ou are a number at the end of the day" is the result of reducing the workplace to economic concerns without properly acknowledging the social value of the workplace in terms of a person's mental health. This sense of feeling undervalued signals erosion to the social connections and damage to the employment relationship. It is why under-resourcing staff and feeling undervalued and unsupported are established psychosocial hazards (Cadieux & Marchard, 2014).

For some participants, the perception that the employer failed to manage resources was to blame for missed calls from PSOs. Participant Q2 explained what that looks like when peer support doesn't happen but perhaps should have:

> I was working with someone just out of Uni. It was his first hanging. It was quite traumatic. Obviously, we had a bit of a chat and a debrief afterwards, like you normally do, and I said, "Peer support will probably give you a call tomorrow." Like I really talked them up; if you have any questions, these people can point you in the right direction. I think it's a two or three-day training course that they go to every year, like a refresher. So, I really talked them up saying they would check on him. They never did.

This participant felt let down that his referral did not amount to a supportive connection. This is an example of failing to meet internal demand for support and can be just as damaging as a lack

of supportive systems. Participant Q10 explained that offering support "might be a nuisance to some people," but that ultimately, people count on this system. He noted that "people notice if you're there and they'll notice if you're not there too." It is important to understand not only how to respond, but how to sustain and enforce that response, especially in times of extreme demand, even if employees do not *seem* to need it.

8.5 Summary Remarks

The *Hegarty* case affirmed in case law that all first responders are exposed to a foreseeable risk through the regular course of their employment. Australian employers must acknowledge this risk, work to identify signs of dysfunction, intervene where signs of dysfunction are present, and assertively enforce safety measures. And they must do so even when there is no guarantee as to how the employee will respond. On the other hand, the employers' duty to care for employees' psychological health is limited by employees' right to privacy. Despite these developments, "… there remains many details to be resolved about the content of employers' duties to avoid foreseeable psychiatry injury to employees" (Freckleton, p. 24). What constitutes a reasonable response from the Australian employer, remains far from clear. Delegating responsibility for psychological health and safety will never be as obvious or straightforward as it is for physical injuries.

The Priority One model is an excellent example of an active attempt to encourage connectedness and the use of preventative psychoeducation and services. The employer takes an active role in addressing the psychosocial reality of the workplace by offering these programs and services but also by constantly putting them "in the face" of paramedics. This reflects a more balanced delegation of responsibility between the paramedic and the employer. When I asked Priority One program developers why the QAS has invested so much in to the prevention of psychological injuries, their answers were two-fold. First, this investment has occurred because prevention is the right thing to do and, second, because it is a legal requirement, affirmed in the *Hegarty* case. The trauma that paramedics encounter cannot be avoided, but the risk it poses to their health can be managed. If the employer is an assertive participant in psychological health and safety measures, paramedics can have *the chance of a better outcome*.

Despite these developments, and the effective framework for preventative care established by Priority One, there are important risks to paramedics' well-being brought about by a dramatic increase in demand for paramedic services. While some of the QAS employees felt that Priority One was an indication that QAS cared for their employees, when it came to meeting demand, participants were far less forgiving. The message that the employer is invested in staff well-being is damaged by mandatory overtime and missed PSO calls amidst high demand and resource lags. So even though the QAS/Priority One model works against the responsibilization of its employees for their own psychological injuries, ultimately, it still exists within the larger system where economic concerns and meeting demand is paramount—something participants considered a serious barrier to maintain adequate psychological health.

Chapter 9: Discussion – Prescribing a Safe System is Not Enough

Paramedics attend more life and death related situations, and time-critical events than all other emergency services combined. This experience carries inherent risk to their psychological well-being (Murray, 2016; Shakespeare-Finch, 2007). In Canada, paramedics' psychological injury rates are the highest among public safety personnel. An estimated half of all paramedics suffer from at least one mental health disorder and they are, overall, more than twice as likely to attempt suicide than the average Canadian (Carleton et al., 2019a; 2019b). It is easy to conclude that first responders who struggle with PTSD or die by suicide have been exposed to too many traumatic experiences. Those on the outside looking in, even those within paramedic culture, wonder why those affected did not reach out for help. Perhaps the stigma was too strong; they were just too proud. Help was available but for whatever reason, they did not access it. Society is drawn to first responders' relationship with trauma in such an intense way that all other possibilities become obscured. What lies beneath the surface, however, are deeper questions about the nature of mental distress, the value of empathy and connection, the organization of work, and the delegation of responsibility and resources.

In this final chapter, I discuss what this study's findings reveal about the current interventions in the Canadian context followed by a review of criticisms of this approach in light of the findings from the Queensland case study. Based on this, I make recommendations for practice, labour policy, and further research. I end with a final word, to summarize and reiterate the proposed paradigm shift for first responders' mental health in Canada.

9.1 Current Interventions and Findings

As one of the busiest paramedic services in Canada, Medavie Saskatoon is run by a private organization that has sought to expand its Employee Assistance Program (EAP) during a national crisis of first responder suicides. Following a move away from Critical Incident Stress Debriefing (CISD), Medavie's current approach included behavioural interventions such as personal counselling and the psycho-educational program Road to Mental Readiness (R2MR). Regarding PPC, which includes counsellors specially trained for first responders, participants in this study generally approved of these counsellors but some wanted a mental health professional with previous experience in paramedicine or emergency services. The rationale was that there is a common language and a common experience with a counsellor who has emergency service experience. This allows paramedics a certain level of comfort that does not exist with a career counsellor.

Regarding R2MR—the most popular psycho-educational, anti-stigma program for Canadian first responders that uses a colour coded continuum model of mental health, participants in this study had mixed feelings, but mostly expressed disapproval. Participants who were program initiators felt it that is was a good starting point that empowered paramedics to take responsibility for their mental health and ask for help when in need. Other participants were less supportive of the program. One participant went so far as to call it a joke. Another participant offered a more objective view, claiming the program contains teachings that paramedics ought to already know. Finally, a participant with a more critical view called attention to ongoing PTSD injuries and suicides despite the widespread implementation of the program. This is consistent with peer-reviewed evaluation of the R2MR program that suggested it does reduce stigma and

increase communication, but it does not actually improve mental health outcomes (Carleton, et al., 2018c). While participants had mixed views of R2MR, an ultimately negative view prevailed because those it was intended to support did not feel supported. This is the risk with the "empowerment" initiatives that ultimately further responsibilize consumers by focusing on individual behaviour with limited consideration for the impact of the social environment (Teghtsoonian, 2009).

With more and more psychologically injured first responders, many Canadian jurisdictions not only expanded their workplace support models, but they also made changes to their Workers' Compensation Acts. Clauses that presume that a psychological injury is work-related (unless proven otherwise) have been introduced to alleviate the burden of proof on injured workers needing compensation and treatment. These amendments are useful in removing the burden of proof from already injured workers, but they are not a cure-all. They risk giving the impression that a lot is being done for first responders' mental health while re-enforcing a complaint-based system, which only helps paramedics once their injuries have already occurred. Participants who worked at Medavie were highly critical of Saskatchewan's WCB. Those who had experience with WCB felt strongly that the system lacked competency. The compensation process was seen as highly contentious and adversarial. Designed to be a safety net, it did not represent safety nor recovery for Medavie participants.

Participants who worked for Medavie were very concerned about PTSD and suicide in their workplace. Participants often had trouble identifying supports they perceived as helpful. These sentiments, of concern for psychological injuries and of a lack of support, were more salient and more frequent than discussion of traumatic calls participants had responded to in the course of their work. This is consistent with relevant scholarship that claims these injuries are more often caused by the lack or severing of supportive connections than the traumatic events themselves. Consequently, the responsibility of trying to identify who might need help and where to get help was a troubling priority for many. One participant summed up the general consensus when she said that soon, it will be "one of their own." There was a strong sense that this burden was overwhelming. While some participants felt it was reasonable to expect those in distress to come forward on their own, other participants felt that coming forward and asking for help was not a safe option given historic cases of workers who ended up isolated, battling WCB, or fired. Overall, the dominant narrative in the Saskatoon case study took a pathological tone in that many participants were focused on how to guard against pathological problems under conditions they perceived as unsupportive. This reflects a neoliberal view of mental health that considers the individual as the only unit of analysis and any deviance as self-contained and pathological (Cosgrove & Karter, 2018; Esposito & Perez, 2014).

In contrast, QAS paramedics offered a more promising narrative, one where posttraumatic stress leads to positive connections and posttraumatic growth. However, it is important not to directly compare the case of Medavie to that of the Queensland Ambulance Service (QAS) given their very different histories and political climates. Medavie Health Services, along with many other Canadian emergency services, are in the beginning stages of developing more effective EAPs. The QAS is a public service and a major contributor to the scholarship of paramedics' wellbeing. The EAP used by QAS, Priority One, was developed over the course of 25 years and today, is the gold standard of first responder support services. In this sense, QAS' Priority One model offers many lessons from which other services can learn.

Founded in salutogenesis rather than pathology, Priority One seeks to normalize posttraumatic stress reactions by teaching paramedics about their inherent predisposition for resilience and posttraumatic growth. Priority One's focus on connectedness through a robust peer support model has, in fact, created a climate of reciprocal support across peers and levels of authority. In other words, Priority One targets the social network of paramedics as much as, if not more than their individual behaviour; a strategy that serves to counter neoliberal logic. As a result, QAS participants readily spoke of posttraumatic stress as a normal and acceptable part of the job. They knew where to seek help and felt confident that Priority One was both competent and accessible. They felt comfortable both in offering and receiving support from peers; especially with Peer Support Officers and supervisors. Most notably, they were unconcerned with PTSD and suicide, considering it was possible, but not likely. The comprehensive program is so effective that QAS paramedics experience subclinical levels of PTSD suicide, well below the average Australian rates (Scully, 2011).

Importantly, participants from both Medavie Saskatoon and QAS Brisbane were concerned about keeping up to the increasing demand for paramedic services. Participants from both case studies described being always on the go, working mandatory overtime, and limited transition time between calls. One supervisor described using his personal time to check-in with his crew. The constancy of incoming calls was seen as a serious barrier to maintaining adequate psychological health. Further, it was interpreted as a message that these employers did not care about the paramedics on the frontlines. This is not a new concern. In 2007, Shakespeare-Finch warned that QAS staffing would need to increase in support of paramedics' psychological health. But ten years later, when I conducted these interviews, all participants felt overworked, referring to the industry as a business in which they were, entirely replaceable. This sense of being overworked and replaceable stems from the economic rationalism that is a hallmark feature of systems governed by neoliberal values.

9.2 Criticisms of Current Interventions

Scholarship on paramedics' mental health has consistently shown that organizational factors such poor social support from peers and supervisors and untenable working conditions, are more significant risk factors than traumatic calls (Drewitz-Chesney, 2012; Murray, 2016; Regehr & Millar, 2007; Shakespeare-Finch & Scully, 2008). Traumatic exposure is an obvious stressor for paramedics however the emergency service organization itself often causes more stress (Shakespeare-Finch, 2007). Paramedics' level of stress is highly dependent on how their employers treat them and how the workload is managed. Participants in this study were clear that the primary source of stress was coming from organizational factors—a lack of support (in the Medavie case) and extreme demand for service (in both cases). Unfortunately, neither Medavie nor QAS were seen to be effectively managing workloads on behalf of their frontline paramedics.

Participants from the QAS, where significant investments had been made into organizational culture and a dynamic view of posttraumatic reactions, presented as much less stressed than those from Medavie, where support programs were still being developed and remained focused on individual behaviour. EAPs like Medavie's that focus on behavioural interventions alone are often considered the "emperor's new clothes" of employee wellness (Arthur, 2000) in that they offer a superficial focus on the individual without taking the broader social context into account. EAPs that fail to address organizational factors in favour of a pathological focus are examples of using individual solutions to solve social problems,

responsibilizing the individual for matters that their employers are better suited to address. Whether from a lack of support or from the extreme demand for service, the level of responsibility placed on paramedics themselves, is far too high.

Understanding the case of Medavie Saskatoon (and the larger Canadian context), in terms of neoliberal approaches to governing the workplace, draws attention to the problematic view that paramedics' mental health problems are self-contained ailments that are a matter of personal responsibility. Participants employed by Medavie who had initiated the new R2MR programming described a changing culture, but one that still focuses on personal accountability. Programs and services such as personal counselling and R2MR, reinforce the personal responsibility narrative by "empowering" (but actually responsibilizing) paramedics to guard against pathological outcomes instead of promoting health and critically evaluating the psychosocial stressors embedded in the workplace that scholars and paramedics have been signaling for years.

In terms of working conditions and the employment relationship, legal scholar Martin Shain (2010) has long called for Canadian employers to recognize that "normal and typically resilient people can be brought to the brink of mental distress, and sometimes pushed over, by conditions of work over which employers have significant control while employees have very little" (p. 47). Paramedics and other first responders are an excellent example of "typically resilient people" who have little control over their work environments and are too often brought to the edge of their capacity. It is a disservice to hold paramedics increasingly responsible for their psychological outcomes without any scrutiny of their employers, particularly given that the risk to paramedics' mental health is foreseeable. Standard EAPs are not enough.

9.3 Recommendations for Practice

EAPs largely happen separately from the workplace and help the employee adapt to the workplace. As we have seen with the Priority One model, however, EAPs can be used to guide the culture within the workplace. What paramedics and other high-risk professions need are work environments where posttraumatic stress is normalized, accepted, and integrated in the professional practice. Much of this can be taught in post-secondary, in a preparatory fashion but the employer also has a role in finding ways to protect transition time between calls and maintaining adequate staffing ratios. It is imperative that employers lead the way by recognizing and protecting workers' vital need for organic, empathic connection between peers and with supervisors while on the job. For the reasons I have indicated in this thesis, this means using health promotion models of care as measures of injury prevention. But first, employers have to be made aware of the true underlying problem and their responsibility to it.

To address Canadian employers' lack of awareness surrounding their duty of care towards the psychological health and safety, a national standard was published by the Canadian Standards Association in 2013, with a 2018 update that specifically addresses paramedics. While the CSA standards are highly regarded (Memish et al., 2017), they are not mandatory and there is no monitoring or enforcement system (Kunyk et al., 2016). Regardless, the CSA standard was never meant to be the sole solution in addressing employer liability, and was intended to provide useful guidelines to establish minimum standards for employers care for employee mental health. To varying degrees, employment standards acts, human rights legislation, collective agreements, workers' compensation acts, occupational health and safety acts, all signal the employers' duty to provide a psychologically safe workplace (Shain, 2010). Of these sources, the occupational health

and safety framework is the most appropriate given its mandate to workplace safety (Shain, 2010). General provisions under occupational health and safety law have yet to be written and in order to effectively govern employer liability here, updated legislation is needed.

9.4 Recommendations for Labour Policy

In order to help paramedics and other high-risk professions, Canadian policy makers must promote a balance of responsibility between frontline workers and their employers. The first step in prevention is mandating the protection of workers' psychological wellbeing (Lippel, 2011). This means reforming provincial OH and S legislation to include a primary duty of care and general provisions for psychological health and safety. The recent history of legislative initiatives regarding discrimination and harassment in the workplace has left open a "doorway of opportunity;" one where employees can "influence the very nature of the employment contract through the vehicle of health and safety law" (Shain, 2010, p. 44). Initiating public policy by targeting the work environment through the OH and S framework, prior to the point of injury is a practical, economical, and ethical alterative to the current complaint-base models (Drewitz-Chesney, 2012; Lippel, 2011; Shain, 2009a, 2010).

Regarding the primary duty of care under OH and S legislation, Canadian employers' duty of care for psychological health and safety is *implied* across multiple legal sources but employers are not explicitly deemed the primary actor. As seen in the QAS model, the legislated primary duty of care played a critical role in the employers' provision of services and ultimately, paramedics' mental health outcomes. Mandating a primary duty of care in Canada could promote a cultural shift where employers take on a more reasonable share of this burden. Expanding OH and S legislation to specifically address the protection of psychological injuries, particularly in high-risk professions would mean that incidents of PTSD and suicide could result in occupational health and safety fines. In a system long informed by individual understandings of mental health, and where economic concerns are paramount, economic sanctions may be powerful motivators for employers to justify spending on preventative measures rather than fines or lawsuits.

Regarding general provisions in OH and S legislation for the protection of psychological health and safety, there are existing frameworks that can provide a starting point. The CSA Standard lists several required actions for psychological safety, many of which could be evaluated for their potential as OH and S measures. In addition, the QAS case suggests that mandating multi-modal, salutogenic programs for high-risk professions (especially focusing on peer support and robust psychological training) is likely to significantly improve workers' mental health outcomes. In terms of the compensation system's response, considerably more attention must be paid to how injured workers are treated under this system. The psychological injury presumption does not ensure adequate care. Everyone heals differently from these injuries (Participant M11) therefore treatment cannot be straightforward. If this system is not beyond repair for the psychologically injured, it has a long way to go in developing competency.

What remains to be seen is whether or not employers in the emergency service industry can and will be held liable for excessive workloads given the emergency nature of their work. Workplace stress is a function of resources versus expectations (Murray, 2016). Funding cuts come at a cost. Participants from both case studies reliably provided narratives of extreme call volume and mandatory overtime that was affecting their health. In fact, for most participants, getting this part sorted seemed to be the biggest piece of the puzzle. Failing to meet adequate

staffing ratios, requiring too many overtime hours or calls per shift will continue to have a devastating impact on paramedics' psychological well-being even where comprehensive, proactive EAPs are provided.

If Canadian policy makers fail to intervene, employers and WCB risk seeing the "floodgates" of psychological injury claims open (Shain, 2010), as clearly shown by the 213% increase in psychological injury claims in Saskatchewan over the last five years (Lozinsky, 2020). Without a new approach, the vital paramedic services that Canadians expect will suffer as the industry adjusts to more and more stress leaves, turnover, and working wounded. In the absence of well-defined legislation, where Canadian judges are increasingly siding with psychologically injured workers (Shain, 2010), employers who fail to proactively and assertively engage in psychological health and safety risk being forced to pay damages. It remains to be seen at what point employers will be held liable for extreme workloads but the immense burden on paramedics will persist. Paramedics will continue to suffer the avoidable yet debilitating hauntings of PTSD. They will continue to respond to the suicides of their own and many of them will die at their own hands; leaving friends, families, and communities, devastated.

9.5 Recommendations for Further Research

Although I often generalize the paramedics' case to all first responders or all high-risk professions, it is important to understand how this general experience also differs across professions. In Canada, first responders' mental health is often discussed as one group but their experiences happen in very different contexts and subcultures. EAPs are optimal when they are tailored to meet the needs of a specific profession or workplace. This means each sector must invest in the research that will identify the specific needs of their workers. Of this group, dispatchers and rural or volunteer first responders are underrepresented in the literature meaning much less is known about their experience of posttraumatic stress and support. While each profession has its own specific needs, there is a need for more research on how salutogenic or health promotion models can benefit Canada's emergency service industry, overall. A good starting point would be to investigate how posttraumatic growth is experienced and supported among these professionals.

Beyond the emergency service industry and other high-risk professions, the way we support people in the workplace is integral to mental health in general. A person's career is often a fundamental part of their identity and worldview. Work life not only serves to offer people a stable income, but a source of connection, fulfillment, and purpose. Research into this reality is on-going. Historically, we have learned a lot about the connection between work and physical health but there is still a lot to learn about how the workplace can promote better mental health. The high rates of work-related psychological injuries in Canada, overall, indicate that developing a more contemporary view of the psychosocial value of the workplace may be in order.

9.6 Final Word

At Jack Spyker's funeral, Spyker's eulogist called out systemic problems for causing the death of his friend. He said, "[o]ur inability to deal with [mental health] as a society hurts and kills people every day." This has been an ongoing struggle for years. In 2007, Canadian researchers Regehr and Millar wrote of Canadian emergency services that "organizations must find ways to increase supports available to workers and increase the sense that their skills and

knowledge are valued and their decisions and opinions are respected" (p. 49), or face troubling consequences. Three years later, the participants I interviewed made the same calls to action.

Work-related psychological injuries highlight the complexities of where the employment contact intersects with human suffering and the potential for posttraumatic growth. The QAS' Priority One and the underlying primary duty of care demonstrate that preventing PTSD and suicide among emergency service personnel is possible given the will and legislation to support it. Canada's first responders' mental health crisis is not a reflection of the individual's relationship with trauma so much as the barriers to support, connection, rest, and appreciation that this profession faces, as a whole.

In order to offer Canadian first responders the chance at a better outcome, emergency service employers must diverge from the unreasonable view that mental distress is a pathological, self-contained ailment that is solely a matter of personal responsibility. Invitations for injured paramedics to come forward along with interventions addressing individual coping styles are being repeated with limited efficacy. Now, it is time to address the emergency service industry's organizational practices. Governments and employers hold considerably more control over the workplace. Accordingly, their interventions must be adjusted as part of an equitable distribution of responsibility for the health and safety of the workplace. Exactly what constitutes a reasonable response in this regard is far from clear, but occupational health and safety legislation is the appropriate legislative foundation and starting point. Even though it is the emergency service industry that is first to face the evolution of psychological health and safety in the workplace, the basic principles apply to the employment contract in general, and all those who fall under it. In the end, it is not just about paramedics; it is about a proper appreciation of labour.

Epilogue

For some years prior to this study, I was a crisis intervention worker, medical social worker, and addictions counsellor in Saskatoon, Canada. As the city grew fast, resources lagged. Working alongside other frontline workers, I got the sense that we all shared a quiet frustration. We called it the "work more with less" ethic. Our clients and patients suffered as well. I found my professional practice had become increasingly about apologizing to clients for policies that just did not work. I watched clients and coworkers despair. In the background, news reports of first responders' suicides began to trickle in. It was obvious to me that it was all connected.

I often tried to find room for discussing better policies but there wasn't ever enough time and little interest from my superiors. After these years of shift work, seeing case after horrific case with no rest in between, my health started to decline. I reached out to one employer for help but was dismissed publically, in front of my peers. The career I once loved had become a serious health hazard. Eventually diagnosed with PTSD, I left this line of work to pursue career in public policy. The years that followed involved a continual mismanagement of my injury by all parties.

While attempting recovery, I began to undertake this research. I was also one of the lead advocates for the presumptive psychological injury clause under Saskatchewan's workers' compensation law. Regrettably, I learned (as many psychologically injured workers do) that this system can and will continue to provoke health challenges. The two years that my claim was investigated along with the year I spent on the program resulted in long-term implications for my health. It became clear to me that changes to workers' compensation were not enough. It is not a safety net but a last resort; a view I shared with participants.

In the interviews I conducted with Saskatoon paramedics, I understood their plight in ways other researchers might not. I recognized their desire to speak openly about how tired and upset they were that their passionate careers were now a source of dislocation. I was impressed with the well-developed solutions they proposed. We value these elite professionals enough to solve the most complicated life and death problems but when it comes to their own suicide epidemic, they don't feel heard. I related deeply. Therein lies my bias. I emphathize with the tired, frustrated worker who is aware of what the solution could be, but is rarely asked.

In Australia, I expected a reality much like my Canadian experience. It was remarkably different. The Queensland Ambulance Service's Priority One team, both past and present, had a manner of "travelling" that was driven by an obviously sophisticated sense of compassion and connection. The depth of their knowledge informed not only their professional roles, but who they were at their core and how they viewed humanity. I may always struggle to explain it, as much as I have tried in this thesis, but it felt *safe.* When I arrived in Australia, I believed that an injured worker like myself would hypothetically be taken better care of under their model. However, as participants illustrated and described their system and way of being, I realized that my injury simply would not have occurred under such a system.

It is important to note that not everyone in my former workplace had an adverse reaction. In fact, many of my former coworkers feel fulfilled and content in the work they do. Similarly, not every Saskatoon paramedic was distressed and not every QAS paramedic was fully satisfied with their system. But the dominant narratives across all cases, were indeed striking. The

remarkable differences between these two cases validated a position I had begun to develop long before I arrived at public policy school—that there is a better, more compassionate way to do business.

Finally and most importantly, I must acknowledge that the frontlines of this PTSD and suicide epidemic are not being fought by the employers or the unions or the policy makers, but by the friends and families of first responders. The greater goal to the ones outlined in this thesis, is to alleviate the burden they face as they carry us across the many gaps in the system. I know with certainty that it is not necessarily our employers, our clinicians, or our governments who provide relief and healing. Instead, it is those who come to our aid whenever called and without hesitation who save us. Those who agonize through intense confusion but choose to believe us anyway. Who never imagined this for their lives but stand firm in reminding us of who we are when we have lost ourselves and all hope for the world.

I was profoundly touched by stories of paramedics returning home to fall into the arms of their loved ones or curl up with their sleeping children. That is the essence of good health. Unfortunately, the broken connections I discussed in this thesis are not limited to the workplace. They can be even more intense at home where the things that happen behind closed doors cannot be regulated or overseen. The emergency service industry will always owe a debt of gratitude to those who stand immediately behind our first responders, for better or for worse.

References

Antonovsky, A. (1996). The salutogenic model as a theory to guide health promotion. *Health Promotion International,* 11 (1): 11-18

Armstrong, J. (2014, July 17). 13 first responders, 13 suicides, 10 weeks. *Global News*. Accessed at https://globalnews.ca/news/1457826/13-first-responders-13-suicides-10-weeks/

Arthur, A. R. (2000). Employee assistance programmes: The emperor's new clothes of stress management. *British Journal of Guidance and Counselling*, 28: 549-559.

Australian Bureau of Statistics (2011). 2011 Census quick stats. http://www.censusdata.abs.gov.au/census_services/getproduct/census/2011/quickstat/3?opendocument&navpos=220

Baynton, M.- A. & Fournier, L. (2017) *The evolution of workplace mental health in Canada: Toward a standard of psychological health and safety*. The Great-West Life Assurance Company: Friesens.

Bergen, R. (2015, Apr. 6). Family of Saskatchewan paramedic speak out on depression*, CBC News*. Accessed at https://www.cbc.ca/news/canada/saskatchewan/family-of-saskatchewan-paramedic-speaks-out-on-depression-1.3022406

Cadieux, N. & Marchand, A. (2014). Psychological distress in the workforce: A multilevel and longitudinal analysis of the case of regulated occupations in Canada. *BMC Public Health*, 14: 808.

Calhoun, L. & Tedeschi, R. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, 9 (3): 455 – 471.

Calhoun, L. & Tedeschi, R. (Ed) (2006). *Handbook of posttraumatic growth: Research and practice*. New Jersey: Lawrence Erlbaum Associates.

Carleton, N., Afifi, T., Turner, S., Taillieu, T., Duranceau, S., LeBouthillier, D., Sareen, J., Ricciardelli, R., MacPhee, R., Groll, D., Hozempa, K., Brunet, A., Weekes, J., Griffiths, C., Abrams, K., Jones, N., Beshai, S., Cramm, H., Dobson, K., Hatcher, S., Keane, T., Stewart, S., Asmundsun, J. (2018a). Mental disorder symptoms among public safety personnel in Canada. *The Canadian Journal of Psychiatry*, 63 (1). 54-64.

Carleton, N., Afifi, T., Turner, S., Taillieu, T., Lebouthillier, D., Duranceau, S., Sareen, J., Ricciardelli, R., Macphee, R., Groll, D., Hozempa, K., Brunet, A., Weekes, J., Griffiths, C., Abrams, K., Jones, N., Beshai, S., Cramm, H., Dobson, K., Hatcher, S., Keane, T., Stewart, S., Asmundson, J. (2018b). Suicidal ideation, plans, and attempts among public safety personnel in Canada. *Canadian Psychology/Psychologie Canadienne,* 59 (3): 220-231.

Carleton, N., Korol, S., Mason, J.E., Hozempa, K., Anderson, G. A., Jones, N. A., Dobson, K. S., Szeto, A. & Bailey, S. (2018c) A longitudinal assessment of the road to mental readiness training among municipal police. *Cognitive Behaviour Therapy*, 47 (6) 508-528.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through grounded analysis.* London: Sage.

Charmaz, K. (2017). The power of constructivist grounded theory for critical inquiry. *Qualitative Inquiry,* 23 (1): 35 – 45.

Cosgrove, L. & Karter, J. (2018). The poison in the cure: Neoliberalism and contemporary movements in mental health. *Theory & Psychology,* 28 (5): 669 – 683.

Crean, F. (2015). *Making the strong stronger. An investigation into how the Toronto Paramedic Services address staff operational stress injuries.* City of Toronto: Office of the Ombudsman. Accessed at https://www.ombudsmantoronto.ca/OmbudsmanToronto/media/Documents/Investigative%20Report/Ombudsman-Report-TPS-November-2015.pdf?ext=.pdf

CSA GROUP Canadian Standards Association /BNQ Bureau de normalization de Québec (2013, 2018). *Psychological health and safety in the workplace: Prevention, promotion, and guidance to staged implementation.* Mississauga: CSA Group.

Csiernik, R. (Ed.) (2005). Wellness and work: Employee assistance programming in Canada. Toronto: Canadian Scholars Press.

Drewitz-Chesney, C. (2012). Posttraumatic stress disorder among paramedics: Exploring new solutions with occupational health nurses using the Ottawa charter as a framework. *Workplace Health & Safety,* 60 (6): 273-276.

Emmerik, A.V., Kamphius, J., Hulsbosch, A., & Emmelkamp, P. (2002). Single-session debriefing after psychological trauma: A meta-analysis. *Lancet,* 360 (9335): 766-771.

Esposito, L. & Perez, F. (2014). Neoliberalism and the commodification of mental health. *Humanity & Society*, 38 (4): 414-442.

The Government of Canada, Department of National Defence (2019). Operational stress injury support program. Accessed at https://www.canada.ca/en/department-national-defence/programs/osiss.html

The Government of Saskatchewan. (1993). The Saskatchewan Occupational Health and Safety Act. Accessed at http://www.worksafesask.ca/wp-content/uploads/2019/06/OHS-Legislation-190611.pdf

The Government of Saskatchewan. (2013). The Saskatchewan Workers' Compensation Act. Accessed at http://www.wcbsask.com/about-wcb/policy/

The Government of Saskatchewan. (2018). The Saskatchewan Human Rights Code. Accessed at https://saskatchewanhumanrights.ca/your-rights/saskatchewan-human-rights-code/

The Government of Saskatchewan (2016). Bill No. 39: An Act to Amend the Workers' Compensation Act, 2013. Accessed at http://www.publications.gov.sk.ca/details.cfm?p=83171 on 29 June 2017.

Hayes, G. & Singh, A. (2012). *Qualitative inquiry in clinical and educational settings,* New York: The Guilford Press.

Hegarty v Queensland Ambulance Service [2007] QCA 366

Hurley, D., Ferriera, S. & Pain, C. (2005) Critical incident stress management. In Csiernik, R. (Ed.), *Wellness and work: Employee assistance programming in Canada.* Toronto: Canadian Scholars Press.

Firman, J. & Gila, A. (1997). *The primal wound: A transpersonal view of trauma and addiction.* New York: State University of New York Press.

Freckleton, I. (2008). Employers' Duties for Reasonably Foreseeable Psychiatric Injuries. *Psychiatry, Psychology, and Law* 15 (1): 17- 24.

Ipsos Reid. (2007, November 19). Factum. Mental health in the workplace: Largest study ever conducted of Canadian workplace mental health and depression. Retrieved from workplacestrategiesformentalhealth.com/pdf/2007_Factum.pdf

Jones, M., Shanahan, E., McBeth, M. (2014). *The science of stories: Applications of the narrative policy framework in public policy analysis*. New York: Palgrave Macmillan.

Kunyk, D., Craig-Broadwith, M., Morris, H., Diaz, R., Reisdorfer, E., Wang, J. (2016). Employers' perceptions and attitudes towards the Canadian national standard on psychological health and safety in the workplace: a qualitative study. *International Journal of Law and Psychiatry* 44: 41 – 47.

Lee, R. (1993). *Doing research on sensitive topics*. New York: Sage.

Leo, G. (2020). Ambulance shortage 'should alarm everyone' as Saskatoon and Regina struggle to keep up with emergency calls. *CBC*. Accessed at https://www.cbc.ca/news/canada/saskatchewan/ambulance-struggle-regina-saskatoon-1.5466792

Lippel, K. (2011). Law, public policy, and mental health in the workplace. *HealthCare Papers,* (Sp. 11): 20 – 37.

Lozinsky, P. (2020, July 3). WCB to roll out psychological safety strategy and resources. *Prince Albert Daily Herald*. Accessed at https://paherald.sk.ca/2020/07/03/wcb-to-roll-out-psychological-safety-strategy-and-resources/

Medavie (Foundation). (2020). Core Causes. Accessed at https://www.medavie.ca/en/community-impact/core-causes/

Medavie Health Services. (2020). About Us. Accessed at https://medaviehs.com/about/

Medavie Health Services. (2018, January 11). Medavie Health Services launches Medavie Health Services West. Accessed at https://medaviehs.com/news/2018/medavie-health-services-launches-medavie-health-services-west/

Medavie Health Services. (2019, February 11). *Finding Solutions to Support Families of Serving and Retired Members of the Canadian Armed Forces and First Responders Suffering with Post-Traumatic Stress (PTS)*. Accessed at https://medaviehs.com/news/2019/finding-solutions-to-support-families-of-serving-and-retired-members-of-the-canadian-armed-forces-and-first-responders-suffering-with-post-traumatic-stress-pts/

Memish, K., Martin, A., Bartlett, L., Dawkins, S., Sanderson, K. (2017). Workplace mental health: An international review of guidelines. *Preventative Medicine*, 101: 213 – 222.

Mental Health Commission of Canada. (2010). *Mental Health First Aid Canada.* 2nd Edition. Ottawa: Mental Health Commission of Canada.

Mental Health Commission of Canada. (2018). *The Working Mind First Responders*. Accessed at https://theworkingmind.ca/working-mind-first-responders?wbdisable=true
**Formerly known as The Road To Mental Readiness*

Mitchell, J. (1983). When disaster strikes. The critical incident stress debriefing process. *Journal of Emergency Medical Services,* 8 (1): 36-39.

Mitchell, J. & Bray, G. (1990). Emergency service stress. Guidelines for preserving the health and careers of emergency service personnel. Englewood Cliffs, NJ: Prentice Hall.

Murray, J. (2016). *Finding the silver lining: Stress, resilience and growth in ambulance practice.* Brisbane: The State of Queensland (Queensland Ambulance Service).

National Defence and the Canadian Armed Forces. (2017). Road to Mental Readiness (R2MR). Retrieved from http://www.forces.gc.ca/en/caf-community-health-services-r2mr/index.page

New South Wales v Fahy [2007] HCA 20.

Patton, M. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Queensland Ambulance Service. (2009). *Trauma and resilience in the workplace: A practical guide for QAS supervisors in supporting employees*. Brisbane: The State of Queensland, Department of Health, internal document.

Queensland Ambulance Service. (2018). *QAS Priority One mental health and wellbeing portfolio*. Edition 1.0. Brisbane: The State of Queensland, Department of Health. Accessed at https://www.aph.gov.au/DocumentStore.ashx?id=03d43503-c257-40da-9b6e-db1350ba88ca&subId=613234

Quenneville, G. (2018, Sept. 16). 'Lost in the shuffle': Regina paramedics' death highlights need for better PTSD supports, parents say. *CBC News*. Accessed at https://www.cbc.ca/news/canada/saskatoon/robbie-curtis-suicide-ptsd-paramedic-regina-1.4825005

Reeve, B. & McCallum, R. (2011). The scope of employers' responsibilities under Australian occupational health & safety legislation. *Australian Journal of Labour Law,* 24: 189 – 213.

Regehr, C. & Bober, T. (2005). *In the line of fire: Trauma and the emergency services.* New York: Oxford University Press.

Regehr, C. & Millar, D. (2007). Situation critical: High demand, low control, and low support in paramedic organizations. *Traumatology*, 13 (1): 49-58

Rose, S., Brisson, J., & Wessley, S. (2003). A systematic review of brief psychological interventions (debriefing) following trauma. *Psychotherapy and Psychosomatics,* 72: 176 -184.

Roth, P. (2017, Jan. 11). 2016 sees rise in first responder suicides. *Victoria News*. Accessed at https://www.vicnews.com/news/2016-sees-rise-in-first-responder-suicides/

Scully, P. (2011). Taking care of staff: A comprehensive model of support for paramedics and emergency medical dispatchers. *Traumatology*, 17: 35-42

Shain, M. (2009a). Psychological safety at work. Emergency of a corporate and social agenda in Canada. *International Journal of Mental Health Promotion,* 11 (3): 42 – 48.

Shain, M. (2009b). *Stress at work, mental injury and the law in Canada*. Ottawa: Mental Health Commission of Canada. Accessed at https://www.mentalhealthcommission.ca/English/media/3043

Shain, M. (2010). *Tracking the perfect legal storm: Converging systems create mounting pressure to create the psychologically safe workplace.* Ottawa: Mental Health Commission of Canada. Accessed at https://www.mentalhealthcommission.ca/English/media/3051

Shakespeare-Finch, J. (2007). Building resilience in emergency service personnel through organizational structures. Paper presented to the 42nd Annual Australian Psychological Society conference: Making an Impact. 25th – 27th September 2007. Brisbane. Pages 362 – 365 Accessed at http://eprints.qut.edu.au/12502/1/12502.pdf

Shakespeare-Finch, J. (2011). Primary and secondary trauma in emergency personnel. *Traumatology*, 17 (4): 1-2.

Shakespeare-Finch, J, & Scully, P. (2004). A multi-method evaluation of an emergency service employee assistance program. *Employee Assistance Quarterly*, 19: 71- 91

Shakespeare-Finch, J., Smith, S., Gow, K., Embleton, G. & Baird, L. (2003). The prevalence of posstraumatic growth in emergency ambulance personnel. *Traumatology,* 9 (1): 58 – 70.

Shakespeare-Finch, J., Wehr, T., Kaiplinger, I. & Daley, E. (2014). Caring for emergency service personnel: does what we do work? In *Australian and New Zealand Disaster and Emergency, Association for Sustainability in Business Inc*., QT Hotel Gold Coast, Surfers Paradise, QLD. Downloaded from http//eprints.qut.edu.au/73083/

Smith, A. (2019, Sept. 9). First responders not immune to scourge of suicide. *Calgary Herald*. Accessed at https://calgaryherald.com/news/local-news/first-responders-not-immune-to-scourge-of-suicide

Statistic Canada (2016). City of Saskatoon Census Profile. Accessed at https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=CSD&Code1=4711066&Geo2=PR&Code2=01&Data=Count&SearchText=4711066&SearchType=Begins&SearchPR=01&B1=All&Custom=&TABID=3

Stone, D. (2002). *Policy paradox: The art of political decision making.* New York: W.W. Norton & Company.

Szeto A., Dobson K., Knaak S. (2019). The road to mental readiness for first responders: A meta-analysis of program outcomes. *Canadian Journal of Psychiatry*, 64 (1_suppl).

Teghtsoonian, K. (2009). Depression and mental health in neoliberal times: A critical analysis of policy and discourse. *Social Science & Medicine*, 69: 28-35.

The Mental Health Commission of Canada (MHCC). (2014). Road to mental readiness (R2MR) accessed at http://www.mentalhealthcommission.ca/sites/default/files/1%252520PG%252520R2MR%252520Police%252520Backgrounder%252520ENG_0_0.PDF on October 28, 2016.

The State of Queensland (Department of Health). (2015). *Annual Report 2014-15.* Accessed at https://www.health.qld.gov.au/__data/assets/pdf_file/0021/439050/annual-report-14-15.pdf.

The State of Queensland (Queensland Ambulance Service). (2019). QAS heritage and history. Accessed at https://www.ambulance.qld.gov.au/history.html

The State of Queensland (2011). Work Health and Safety Act. Accessed at https://www.worksafe.qld.gov.au/laws-and-compliance/workplace-health-and-safety-

laws/laws-and-legislation/work-health-and-safety-act-2011 (The State of Queensland, 2011)

Wastell, C. (2002). Exposure to trauma: The long-term effects of suppressing emotional reactions. *The Journal of Nervous and Mental Disease*, 190: 839 – 845.

Workers' Compensation Board of Saskatchewan. (2019). Amendments to the Workers' Compensation Act to recognize psychological injury. Accessed at http://www.wcbsask.com/ptsd/

Appendix A: Semi-Structured Interview Questions for Paramedics

Cluster 1: Professional Role

- Can you tell me about how and why you chose this profession?
- How is this work similar or different from what you expected?
- Has the work changed since you started in the profession? If so, how?
- What does this work mean to you?
- What advice might you give to someone considering this profession or someone new to this line of work?
- What is some valuable advice you have been given from another in your profession?
- What would you like the general public to understand about this profession?

Cluster 2: Stress & Resilience

- How do you stay healthy in this profession?
- How is a paramedic expected to act on the job?
- How do you deal with that stress? At work and at home?
- What helps make this career sustainable?
- What does the term operational stress injury mean to you?
- Can you identify policies that are either helpful or harmful in regards to coping with operational stress?

Cluster 3: Resources & Support

- How do you define support?
- What formal or informal resources are provided for you to deal with stress and/or traumatic events?
- What does support look like in your workplace? What makes it work? What hinders it from working?
- What can help prevent psychological injury/OSI? Or is it preventable?
- What resources are available for those unable to work due to a psychological injury?
- What are some signs that someone may be experiencing an operational stress injury?
- Have you ever felt the need to ask for emotional or psychological support from a coworker, supervisor or manager? How have you, or would you ask for help or support?
- How would you respond if a coworker expressed a need for psychological support?
- How important is teamwork and what kind of environment is needed for a team to thrive?

Appendix B: Semi-Structured Interview Topics for Decision-Makers

- Formal and informal support services for first responders.
- Funding for support services for first responders.
- Recruitment procedures for support services.
- Measures used to determine the efficacy of support services.
- Perceived challenges of addressing the psychological demands endured by first responders.
- Perceived presence and effects of peer support and leadership in the area of jurisdiction.
- A review of pertinent policies and procedures that address peer support, leadership and operational stress injuries.
- Perceived duty of care.

Appendix C: Participant List

Medavie (Saskatoon, Canada)		QAS (Brisbane, Australia	
#	***Role***	#	***Role***
M1	On Road Paramedic	Q1	On Road Paramedic
M2	On Road Paramedic	Q2	On Road Paramedic
M3	On Road Paramedic	Q3	On Road Paramedic / Supervisor
M4	Key actor / On Road Paramedic / R2MR Instructor / Committee Member	Q4	On Road Paramedic / Peer Support Officer
M5	On Road Paramedic	Q5	On Road Paramedic / Acting Supervisor
M6	On Road Paramedic	Q6	On Road Paramedic / Supervisor
M7	On Road Paramedic	Q7	On Road Paramedic / Acting Supervisor
M8	On Road Paramedic	Q8	On Road Paramedic
M9	Key Actor / On Road Paramedic / R2MR Instructor / Committee Member / Supervisor	Q9	Key Actor
M10	Key Actor / On Road Paramedic / Policy Developer	Q10	Key Actor
M11	Key Actor	Q11	Key Actor
M12	Key Actor / On Road Paramedic / Union Representative / Supervisor	Q12	Key Actor
M13	On Road Paramedic / Supervisor	Q13	Key Actor
		Q14	Key Actor

Appendix D: Thematic Codes

1) **Initial Codes**

PTSD & Suicide
Help-Seeking Barriers
Suck It Up
Generational Differences
Need for Positive Feedback & Recognition
Perceptions of Supervisors
Perceptions of the Employer
Peer Support (Informal)
Connectedness
Confidentiality
Trust
Work-Life Balance
Personal v. Professional Problems
Resilience/Posttraumatic Growth
Personal Counselling
Psychoeducation / R2MR
Peer Support (Formal)
Expectations v. Reality
Time (Transition Time & Overtime)
Call Volume
Offloading/Ramping
Regular Service Users
Low Acuity Calls
Critical Incidents
Racism
Substance Abuse
Public Perception
Media (Representation of PTSD, Suicide, and the Profession)
Messages from the Organization
Leadership
Funding & Resources (Government Contract)
Workers' Compensation (Government, Cost to the Employer)
Prevention
Union
Changes in Governance (Corporate, Amalgamation)
Managing Generations
Employee Privacy
Scope of Practice
Career Pathing/Career Sustainability

2) **Actors**

Individual/Paramedic
Partner/Crew
Supervisor
Employer
Employer (EAP)
Government (As employer or contractor, WCB)
Community
Union
Media
Post-Secondary

3) **Categories (Revised Codes)**

Paramedic Culture
Critical Incidents
Impact of the Job
Knowing Your People
Individual Responsibility
Burden of Injury
EAP
After the Call
Environmental/Org. Stressors
Getting Help
Unable to Work
Injured Workers
PTSD & Suicide
WCB
Perceptions of the Employer
The Employer's Perspective
Connection with Peers and Supervisor
Meeting Demand